

# The Psychiatric Quarterly

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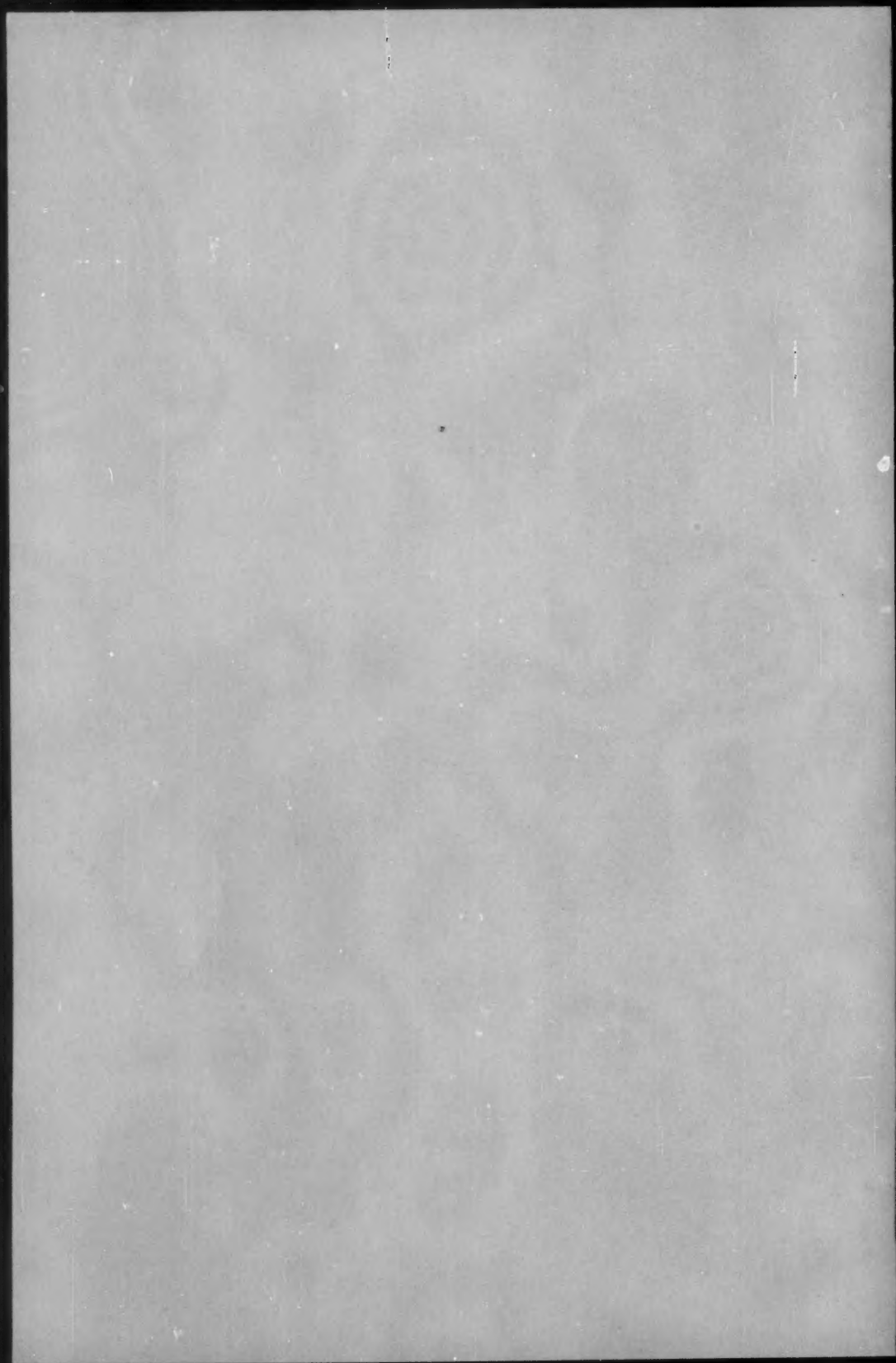
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## SOME ASPECTS OF SELF-MUTILATION IN THE GENERAL POPULATION OF A LARGE PSYCHIATRIC HOSPITAL\*

BY RICHARD H. PHILLIPS, M.D. AND MUZAFFER ALKAN, M.D.

The phenomenon of self-mutilation in its many varied and occasionally dramatic forms is well known to almost every psychiatrist, and is a symptom of considerable clinical importance as far as understanding and management are concerned. The authors considered the entire population of a large psychiatric hospital, Willard State Hospital, Willard, N. Y., as one aspect of a larger study, to determine more about the nature and the extent of such injuries.

Self-mutilation by definition denotes those measures carried out by the individual, upon himself, which tend to cut off, to remove, to maim, to destroy, to render imperfect some part of the body. Through common usage, the term mutilation connotes a socially unacceptable alteration of the physical form. Haircutting, fingernail clipping, shaving, eyebrow plucking, and the like are not, in America, today, classified as mutilations. Neither are more irreversible practices such as medical and religious circumcision, nor certain cosmetic surgical procedures. Some phenomena like intense nail-biting and decorative tattooing lie on a kind of equivocal line between the socially acceptable and socially unacceptable self-initiated bodily alterations. Induced abortion, although socially quite unacceptable, does not appear to be thought of in our culture as "mutilation." For purposes of classification in the initial screening procedure, the authors made use of a social or common-sense evaluation of what is or is not mutilation. The head nurse of each ward in the hospital was asked to prepare a list of all of the patients, under her immediate supervision, who tended to harm themselves. In each case, the nurse served as the agent of today's society in establishing what is or is not acceptable behavior in regard to bodily alteration. As might be expected, this presented no problem, since these nurses are constantly on the alert to detect persons so disposed, and then to distract, dissuade, or otherwise prevent them from causing "self-injury."

The lists were compiled, and every patient reported was examined for screening purposes by one of the authors. Injuries which appeared to result primarily or secondarily from such things as

\*From the department of psychiatry, State University of New York, Upstate Medical Center in Syracuse, and Willard State Hospital, Willard, N. Y.

skin diseases, old wounds, allergic reactions to medication and the like, were excluded from consideration. Otherwise, all self-inflicted injuries, regardless of the age of the patient or the primary diagnosis, were included.

The results of the findings can be demonstrated most easily in Table 1.

Table 1. Willard State Hospital, March 1959

	Population	Number of Self-Mutilators	Percentage of Self-Mutilators
Total .....	2,816	121	4.29
Male .....	1,292	28	2.17
Female .....	1,524	93	6.10

Ratio of percentage of male mutilators to percentage of female mutilators: 1 : 2.81.

Surveying the character of the injuries, it became readily apparent that the attacks of the males upon themselves were apt to be far more violent in nature. Whereas the great majority of the women examined either scratched, picked, or dug at their skin, often causing bleeding, the men tended more to strike themselves in the head, chest, and face, bruising their bodies, blacking their eyes, and the like. Four of the females studied had histories of swallowing sharp objects such as pins and needles. Although the authors are well aware of the fact that men do occasionally ingest foreign objects, they did not encounter this phenomenon in any of the males. Two of the men had mutilated themselves in attempting the removal of the penis or testicles, while in no case did the authors encounter an instance of assault on her genitalia by a woman. It was not the purpose in this part of this study to formulate psychodynamic patterns of self-mutilation, but rather to determine grossly some of the characteristics of its occurrence.

Perhaps the most impressive of these was the fact that there is a rather striking difference in the frequencies with which males and females tended to present a management problem in terms of injury to the body. This is especially interesting when it is considered in relation to the sex differences in successful suicide. Statistics summarized by Dublin and Bunzel in 1933<sup>1</sup> indicate that in practically all European countries more males commit suicide than do females, in the ratio of approximately three or four to one. A similar pattern is also found in this country in recent years. This is demonstrated in Table 2, compiled from *Vital Statistics of the United States*.

Table 2. Suicide Statistics of the United States 1953

	Total	Male	Female	Ratio Male to Female
Total .....	15,947	12,534	3,413	3.67 : 1
White .....	15,307	12,008	3,299	3.64 : 1
Nonwhite .....	640	526	114	4.61 : 1

In examining these studies, the ratio of suicide in males to that in females is something over 3 : 1, while the ratio of self-mutilation in males to that in females is slightly under 1 : 3; one being the inverse of the other.

While suicide, generally, is without question a predominately male phenomenon, the authors feel their study strongly points toward the fact that mutilation of the body short of suicide is predominately a female phenomenon.

#### SUMMARY

The entire population of a large psychiatric hospital was screened with regard to the clinical symptom of self-mutilation. One out of every 23 patients, or 4.29 per cent, presented as at least one symptom a significant tendency toward self-injury. The attacks of men upon their bodies appeared generally more violent than those of women upon theirs. The frequency of self-mutilation by males was strikingly less than by females, 1 : 2.81. This frequency of self-mutilation, short of suicide, was almost the inverse of that of accomplished suicide in males as compared with females, 3.67 : 1.

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## RECURRENT SELF-MUTILATION\*

### *A Case Study in Morbid Mood and Behavior*

BY RICHARD H. PHILLIPS, M.D., AND MUZAFFER ALKAN, M.D.

*Dear and dear is their poisoned note  
The little snakes, of silver throat  
In mossy skulls that nest and lie  
Ever singing "die oh! die."\*\**

THOMAS LOVELL BEDDOES

Self-mutilation, which the writers have defined elsewhere as a socially unacceptable alteration of physical form, occurs with greater frequency than is generally believed.<sup>1</sup>

Most dramatic self-mutilations occur in individuals who are severely psychotic. Occasionally, however, one encounters a patient who is intelligent and apparently in fairly good contact with reality, who appears intent upon self-destruction short of suicide, indeed at times is thought of, perhaps, as a "suicidal malingerer" by those who are about him. The writers have selected such a person, primarily to demonstrate a relationship between morbid mood and behavior.

On November 5, 1958, a young woman, who will be called Alice, was readmitted to a New York state hospital. She was depressed, frightened, and panicky. At the end of her financial rope, she had apparently made the veiled threat to one of her friends, that if her parents did not give her money she might kill them. There had been a more tangible threat to her own life in the form of an overdose of aspirin, with suicidal implications.

Alice was a small, slender, wiry, blonde, boyish-looking woman of 28, who on physical examination, which otherwise showed negative results, revealed numerous signs of bodily injury, all of which proved to be self-inflicted. There was a scar approximately seven inches long on the right side of her face, with several smaller scars near the right temple, a large scarred area on her

\*This paper is from the department of psychiatry, State University of New York, Upstate Medical Center in Syracuse, and Willard State Hospital, Willard, N. Y.

\*\*From *The Phantom Woer*. Beddoes, the author of these lines, was an English physician born in 1803. His numerous poems and his poetic play, *Death's Jest Book*, despite their extremely morbid content, compare favorably with the most beautiful lyrical poetry ever written in the English language. In 1849, after repeated attempts, Beddoes committed suicide.

left temple, and two large scars on the right side of her neck. There were multiple scars on her right hand and wrist, and several scars on her left upper arm. There was evidence of many deep linear gashes running from the left wrist all the way up her forearm. These resembled strikingly the service stripes on the coat of a master sergeant with 30 years of service. In addition to all of these, there was another incision on the bottom of her left foot, and an old wound of the chest beneath her left arm. This history of repeated self-mutilation dated back to a time shortly after her graduation from college some six years before. No objective evidence of illness existed before that time, although the patient was aware of becoming progressively more anxious and moody during her senior year.

While an attempt was being made to gather background information, it was learned that this patient was interested in art, and had chosen the subject as her major in college. She almost eagerly produced examples of her work, some of which are included in this paper. She was not asked to draw any of these pictures, nor was any attempt made to use them as an adjunct in treatment. They are presented, therefore, only as her own artistic expression of mood.

Alice was born in Chicago on April 30, 1930. Her actual parents were unknown to her, but she had been placed in the hands of a reputable agency, and was adopted by her foster father and mother when she was 23 months old. (See Figure 1.) There was one other child in the family, a son born to these foster parents who was two years older than she. She recalled very little of her childhood except that her parents, who were wealthy, were quiet and emotionally unapproachable, encouraging her to withdraw to the end of the room to color or draw. They paid no attention to her work except to say, "That's nice, dear," and when her art work appeared in school publications, they did not recognize it as hers.

Her parents said they had informed her early of her adoption. They also observed, that, as a small child, she had always wanted her own way, was impulsive and often in mischief. They said that she wanted "to be in everything" and that if she could not accomplish inclusion in the group by acceptable means, she would use unacceptable ones. They felt they had been too lenient with her.

Alice began school at the age of six and one-half years, and because of superior intelligence, never had any academic difficulty. While she was still in the primary grades, she was sent away to an exclusive boarding school (See Figure 2), a type of life which was maintained for her until she finished college. In this setting, she always appeared to adjust well. Because of her athletic ability, she played on all of the school teams, winning a number of prizes. Away from the playing field, she was chosen as leader in other group activities. Despite all this, she managed to develop the rather fixed opinion that she was neither very bright nor really accepted by the others of her own age. She felt they liked her for what she did rather than for what she was, and she early adopted the role of the group "clown."

During the summer vacations she did not spend much time at home, but rather traveled to camp (Figure 3) where, because of her experience and leadership ability within an institutional setting, she took over the responsibility of caring for other children. She felt her parents did not like her, since they never asked her about what she was doing.

Following high school, she was brought home for her debut which proved to be a torturing experience for her (Figure 4). She preferred the freedom of blue jeans and the open air of the athletic field to the confinement of an evening gown in a place where she felt she did not belong, crowded among people who were unknown to her.

Alice was relieved when she was accepted for admission at a small college for girls. Here, as in all the boarding schools she had attended, she appeared to adapt well. Her academic performance was good. She worked at her art for long periods, and made a significant contribution to campus life by illustrating the year books. The only apparent change from her previous life took place in the area of religion (Figure 5). She had been brought up as a Protestant, and, while in college, she made a shift to the Roman Catholic faith, feeling that she wanted to belong to a "strong" religion.

During her senior year, she listened to her classmates as they made plans to go to New York City to seek their fortunes, or to become, for a while, a part of a busy life, before returning to their small home towns to settle down. She thought of herself



Figure 1.



Figure 2.



Figure 3.

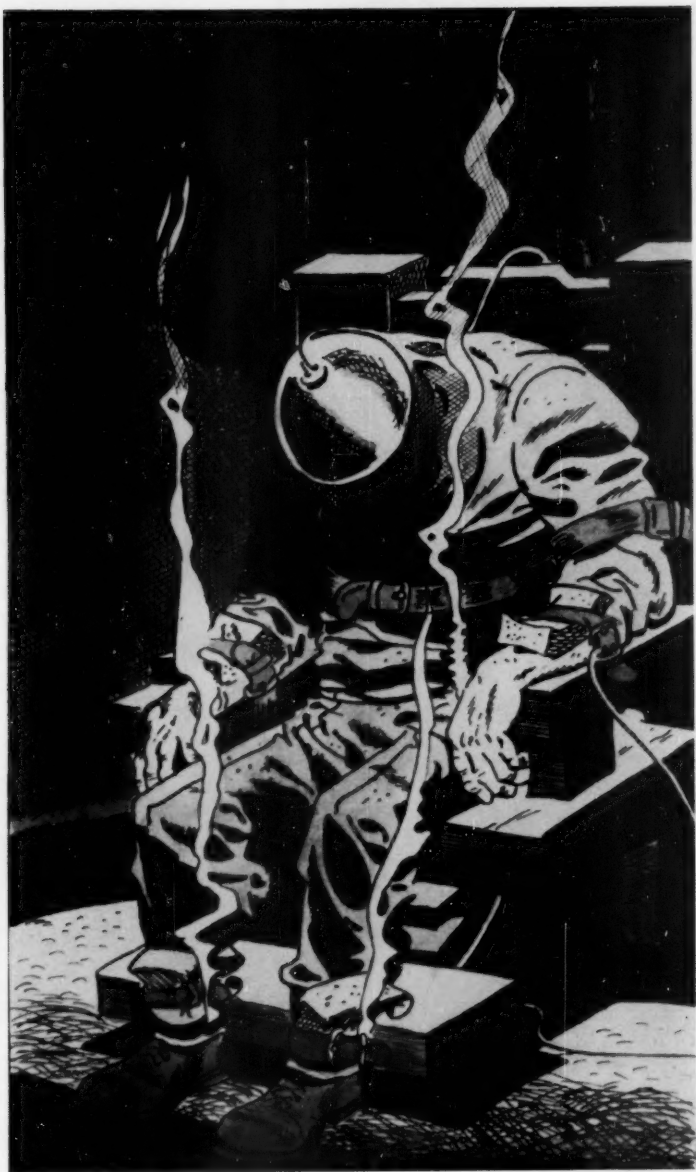


Figure 4.



Figure 5.



Figure 6.



Figure 7.

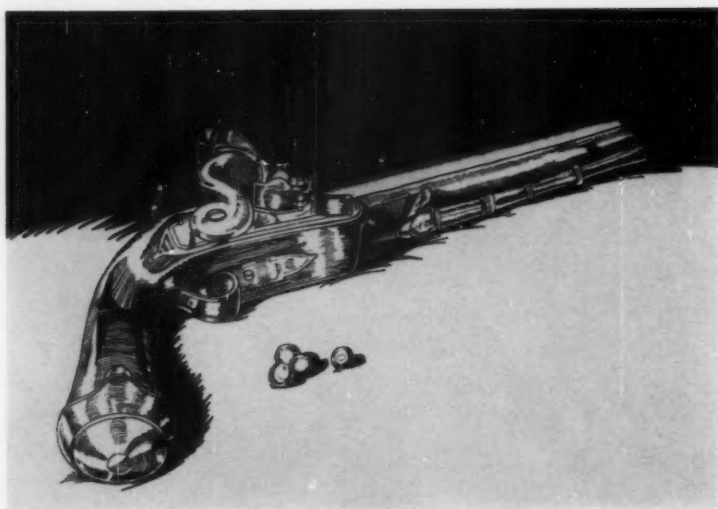


Figure 8.



Figure 9.



with despair (Figure 6). She had no plans, she wasn't going anywhere. She didn't know what to do.

Graduation came, and her classmates departed, but Alice lingered on. During the summer, she opened a small dining room across the street from the college campus. She managed poorly, felt sorry for the students who patronized her establishment, and charged so little that she could not even pay her operating expenses.

She received two inheritances. The first, of \$1,000, she gave away as a memorial fund to a revered teacher. The second, of \$50,000, was placed in trust for her by her father who sent her approximately \$90 a month.

Alice had a few eccentric friends; and several stable members of the community tried to help her, but she became more morose and isolated. She would drive aimlessly around the countryside, or, dressed in blue jeans and carrying a knife, she would wander about the fields outside of town (Figure 7), killing time. Then, in 1952, her loneliness and isolation became intensified, and she slashed her wrists, but was not hospitalized. From this point on, things began to happen quickly.

In 1953 she married a strong uneducated farmer who was nice to her; but she did not become pregnant. In 1954, she began to drink excessively and smashed her car into a tree. A little later that year, she argued one evening with her husband over some insignificant matter, and, taking his gun, wandered away from home the next day (Figure 8). Indecisively, she shot at some tin cans placed on fence posts for a while, and then she shot at herself. She was picked up by a passing car, and taken to a general hospital where she was treated, making a rapid recovery except for some residual paralysis of the left arm, resulting from injury of the brachial plexus.

It was not until considerably later, in 1954, that she was first admitted to a state hospital for psychiatric study and treatment. At that time she was alternately depressed and excited, untidy and un-co-operative. She refused to eat and lacerated her hands, smashing a window. She had nine electric shock treatments with some symptomatic improvement and was transferred to a private hospital early in 1955.

Alice was discharged from the private hospital after two months to find that her husband had left the country, ostensibly for her

good—a separation which later terminated in divorce. She made a borderline adjustment in her college town for a few months before lapsing once more into mutilation endeavors. She was readmitted to the state hospital where she remained for only two months, pressing for her own discharge.

Arrangements were made for out-patient care at a community clinic, and from 1955 to 1958, she remained outside the hospital. Her pattern of adjustment left much to be desired during this period. She lived in poverty, attempting to do some professional art work locally. When her small check came each month, she immediately gave it away or spent it buying drinks for others at the local taverns. Then, without money for food, she would scour the streets of the town for pop bottles on which she collected the deposits to buy hamburgers. The pattern of self-mutilation in periodic bouts continued, followed by shame on her own part, and a sense of irritation, disgust and hopelessness on the part of those in the community who wanted to help her.

In September 1958, the person treating her at the community clinic moved away, and the self-destructive behavior reached a new pitch. She cut her left arm almost immediately, and then, in October 1958, slashed both her wrists and the side of her face. In November 1958, she was readmitted to the hospital. Attempts at intensive psychotherapy were begun by one of the authors. At times, Alice seemed depressed and hopeless. At other times, there was pressure of speech and activity. Her art productions during this period seemed to reveal attempts at assumption of the role of clown, which she had played in other institutions. One elaborate drawing with depressive undertones (Figure 9) was replete with a shrunken head, the Mad Hatter, nuts, loose screws, tablets of equanil and miltown, idiots, cut-out paper dolls, and bats, intermingled with symbols of the arts and education.

Various theories have been formulated to explain this paradoxical type of attempt toward adaptation, this apparent violation of the "pleasure principle" through self-mutilation.

Menninger,<sup>2</sup> for example, who suggests the term "focal suicide" to cover a number of phenomena including self-mutilation, malinering, compulsive polysurgery, certain unconsciously purposive accidents, and sexual impotence, states the following: "It is absolutely essential to the development of our theory, however, that we demonstrate that the suicidal impulse may be concentrated upon

a part as a substitute for the whole. Self-mutilation is one of the ways in which this is done..."

This idea of the focus upon the part, and perhaps its dissociation from the whole in order to spare the latter, is not only reminiscent of numerous hysterical phenomena, but of a Biblical injunction as well: "And if thy right hand offend thee, cut it off and cast it from thee; for it is profitable for thee that one of thy members should perish, and not that the whole body should be cast into hell."\*

Szasz<sup>2</sup> has provided an additional theory regarding self-mutilation: "This state," he notes, "occasionally leads to the actual removal of parts of the body by the patient, expressing the ego's need to bring the body up to date, so to speak, in order that it correspond to the psychically amputated (new) body image." Because the body part is already lost from the point of view of the experiencing ego, he explains, its removal is unaccompanied by pain.

Fenichel,<sup>4</sup> in discussing self-castrations as they occur as one aspect of behavior in catatonic states, says: "These acts probably are psychologically comparable to auto-castrations performed by religious fanatics who, by such radical denial of their active sexual wishes, try to regain 'peaceful unity with God,' that is, an extreme passive submissiveness, less of a feminine than of an early infantile 'oceanic' nature."

The writers have considered each of these theories carefully. While they provide helpful approaches to the understanding of the phenomenon, the clinical material obtained during the work with Alice suggests an additional theory, which is more distinctly interpersonal in nature, in regard to self-mutilation. The motivation for her behavior seemed overdetermined. First of all, she sought to punish her parents, and later on her parent substitutes, for their cold disinterest or emotional neglect and desertion. In this way she expressed indirect hostility toward them by showing their delinquency, since "a well-cared-for child comes to no harm." Second, she attempted to correct the situation for which she was punishing her parents by presenting them with the picture of an "injured and bleeding child," the scene most likely to bring a parent to her quickly with expressions of tenderness and concern. That her behavior accomplished only temporary results

\*Matthew 5. 30.

seems best explained by the mutual frustration and anger it caused both herself and her parents.

After her discharge from the hospital Alice was followed in treatment by one of the authors (M.A.) for two and a half years. Her early mistrust of the doctor and her sarcastic attitude toward psychiatry disappeared after several months. While her style of living, with a tenuous borderline social adjustment, actually changed little, she developed a rather intense attachment to the therapist, which appeared to control actual self-mutilation during the period of treatment.

In addition to her regular visits to the hospital, which occurred twice weekly, she demonstrated a longing for additional contact. The 80 letters which she sent to the therapist during this time were long and carefully written, although the content of some showed a significant lack of organization. On the outside of many of the envelopes of these letters were elaborate pictures drawn by herself, many suggestive of an illuminated manuscript. Each picture contained an expression of how she felt at the time; but even in the saddest pictures, there was the playful quality of a clown.

On several occasions she showed the therapist photographs of herself taken before she first began the assaults on her own body. She stated her firm belief that she could not undo the things she had done in the past—that it was “too late, and futile to try again.”

Although this patient was officially diagnosed as “without psychosis, psychopathic personality with asocial trends,” the authors were constantly impressed by an underlying mood disturbance, a depressive core upon which most of her psychopathology was based and which was perhaps best expressed by her own startling graphic productions.

#### SUMMARY

Self-mutilation is encountered more frequently than is generally realized. To the psychiatrist it often presents a kind of paradox in the spectrum of human behavior. This paper centers around a dramatic example of repeated self-mutilation. The underlying mood of the woman described is highlighted by a series of her own artistic expressions.

A number of contemporary theories regarding self-mutilation are reviewed briefly, and an interpersonal theory is formulated which the writers feel may be helpful in understanding some episodes of violence done to the self.

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## EFFECTS OF PREMEDICATION WITH MEPROBAMATE AND PHENOBARBITAL ON ADRENOCORTICAL RESPONSE TO ECT

BY FRANK CO TUI, M.D., WALTER BRINITZER, M.D., AND  
ALFONSO ORR, M.A., M.S.

Among the many studies of adrenocortical response to stressful stimuli is the work of Bliss, Migeon, Nelson, Samuels and Branch<sup>1</sup> which showed that ECT is followed by a rise in the level of hydrocortisone in the blood whether the ECT is administered by the glissando or the Reiter technique and that the change is blocked by diphenylhydantoin sodium, or SKF 2599, in doses large enough to block grand mal seizure.

The patterns of adrenocortical response in three different circumstances are reported in the present article, as follows: Part 1: Patients awaiting ECT (a) with and without meprobamate (columns B, I<sub>1</sub>, and I<sub>2</sub>, Table 1), and (b) with and without phenobarbital premedication (columns B, I<sub>3</sub>, Table 2). Part 2: Post-ECT with and without meprobamate premedication (Series A and B, Table 1). Part 3: Post-ECT with and without phenobarbital premedication (Series C, Table 2).

### MATERIAL AND METHODS

Twenty-eight recently admitted\* male psychotic patients, aged 19 to 54 years with diagnoses of schizophrenic reactions, were subjects of the study. Table 1 presents the diagnostic subgroups. The entire 28 were subjects for Part 1; 20 were subjects in Series A and B of Part 1; and eight were subjects of Series C, Part 2. In Part 1, one day before ECT, 20 ml. of blood were drawn from the antecubital vein in the post-absorptive state at 9:00 a.m. for the "basal" values of column B. These are shown in Table 1, Series A and B. On the day of ECT, patients in the postabsorptive state who were exposed to the experience preceding ECT had additional samples drawn for the I<sub>1</sub> values (unpremedicated) of Series A, Table 1; and for the I<sub>2</sub> values (meprobamate-premedicated) of Series B, Table 1. Similar samples were drawn for the I<sub>3</sub> values (phenobarbital-premedicated) of Series C, Table 2. A comparison of the B values in the columns of the tables

\*To Creedmoor (N.Y.) State Hospital.

Table 1. Hydrocortisone Levels in the Peripheral Blood, Pre- and Post-ECT  
Series A: ECT Without Premedication

Name	Age	Diag.	B μg. %	Date	I <sub>1</sub> μg. %	I <sub>1</sub> /B %	30' μg. %	30'/I <sub>1</sub> %	75' μg. %	75'/I <sub>1</sub> %	135' μg. %	135'/I <sub>2</sub> %
B1	30	DPU	14.6	10/22-23/57	12.5	86	11.3	90	21.8	174	26.0	208
B2	23	DPU	11.3	"	21.5	190	25.6	119	25.7	120	26.4	109
D1	19	DPU	15.3	"	27.8	182	—	—	30.7	110	10.3	37
F1	27	DPM	15.5	"	23.7	153	38.3	162	38.1	161	36.5	154
C1	48	DPP	25.0	12/17-18/57	29.5	118	25.3	86	37.9	128	35.4	120
F2	26	DPP	15.4	"	35.3	229	33.9	97	52.0	148	35.8	101
S	25	DPU	12.1	"	45.0	372	38.0	84	43.4	96	36.8	82
W	30	DPP	12.2	"	—	—	51.0	—	52.9	—	46.6	—
B3	19	DPC	10.1	2/18-19/58	24.8	246	41.8	169	27.2	110	11.8	48
E	19	DPP	tr*	"	17.2	1726	25.3	147	31.7	184	23.1	134
M	28	DPM	15.9	"	18.4	116	11.8	64	19.8	108	10.6	58
O	26	DPM	9.1	"	14.0	154	21.0	150	22.3	159	33.6	240
F3	35	DPP	18.0	3/18-19/58	22.1	123	22.1	100	31.3	141	20.3	92
N	19	DPU	13.5	"	43.0	319	27.9	65	23.1	51	18.8	44
R1	35	DPP	14.4	"	10.3	72	24.7	240	22.1	216	18.6	181
R2	23	DPP	15.6	"	34.3	220	38.1	111	24.8	72	28.2	82
C2	21	DPU	9.6	4/15-16/58	25.7	268	21.5	84	34.8	135	20.6	80
D2	53	DPP	17.2	"	12.4	72	23.8	192	47.6	384	6.4	52
F4	53	DPM	22.3	"	21.4	96	24.6	114	27.6	129	10.5	50
L	39	DPP	24.6	"	15.3	62	38.4	251	33.6	213	21.3	139
			14.6		23.9	170	28.6	120	32.4	136	23.9	100
Mean					9.77		10.11		9.82		10.72	
S.D.			5.46									

DPU—dementia praecox, undifferentiated

DPM—dementia praecox, mixed

DPC—dementia praecox, catatonic

DPP—dementia praecox, paranoid

\*—For purposes of computation, this value has been raised to 1.

Table 1. Hydrocortisone Levels in the Peripheral Blood, Pre- and Post-ECT (Concluded)  
Series B: ECT With Meprobamate Premedication

Name	Age	Diag.	$\mu\text{g.}\%$	Date	$I_2$ $\mu\text{g.}\%$	$I_2/I_1$ $\%$	$30'$ $\mu\text{g.}\%$	$30'/I_2$ $\%$	$75'$ $\mu\text{g.}\%$	$75'/I_2$ $\%$	$135'$ $\mu\text{g.}\%$	$135'/I_2$ $\%$
B1	30	DPU	14.6	10/30/57	2.8	22	16.6	593	22.8	814	11.8	421
B2	23	DPU	11.3	"	6.5	30	14.2	218	24.0	369	17.6	271
D1	19	DPU	15.3	"	9.8	35	23.3	238	23.3	238	18.2	186
F1	27	DPM	15.5	"	11.2	47	24.6	218	30.6	273	22.0	196
C1	48	DPP	25.0	"	15.3	52	19.5	127	17.5	114	22.1	144
F2	26	DPP	15.4	"	11.3	32	21.0	186	32.3	283	25.8	228
S	25	DPU	12.1	"	28.5	63	17.1	60	33.3	117	35.6	125
W	30	DPP	12.2	"	14.2	—	27.3	192	27.0	190	20.3	143
B3	19	DPC	10.1	1/8/58	22.0	89	32.6	148	29.7	135	12.5	57
E	19	DPP	tr*	"	6.2	36	26.4	426	16.9	273	27.0	435
M	28	DPM	15.9	"	15.5	84	16.5	106	14.0	90	17.9	115
O	26	DPM	9.1	"	14.2	101	48.8	344	14.2	100	4.5	32
F3	35	DPP	18.0	3/26/58	10.4	47	25.6	244	20.5	197	14.2	137
N	19	DPU	13.5	"	10.8	25	29.0	269	13.9	129	10.2	94
R1	35	DPP	14.4	"	26.8	202	27.7	133	15.8	76	12.0	58
R2	23	DPP	15.6	"	22.1	64	36.7	166	30.5	138	15.1	68
C2	21	DPU	9.6	4/23/58	20.6	80	25.6	124	33.5	163	31.4	152
D2	53	DPP	17.2	"	6.4	52	29.0	453	41.3	645	44.0	688
F4	53	DPM	22.3	"	10.8	50	27.7	256	27.6	256	4.8	44
L	39	DPP	24.6	"	21.3	139	36.7	172	11.6	54	35.3	156
Mean			14.6	"	14.0	58	28.3	221	24.0	171	20.1	165
S.D.			5.46		6.60		8.01		8.14		10.28	

DPU—dementia praecox, undifferentiated

DPM—dementia praecox, mixed

DPC—dementia praecox, catatonic

DPP—dementia praecox, paranoid

\*—For purposes of computation, this value has been raised to 1.

Table 2. Hydrocortisone Levels in the Peripheral Blood Pre- and Post-ECT  
Series C: ECT With Phenobarbital Premedications

Name	Age	Diag.	B μg. %	I <sub>3</sub> μg. %	I <sub>3</sub> /B %	30' μg. %	30'/I <sub>3</sub> %	75' μg. %	75'/I <sub>3</sub> %	135' μg. %	135'/I <sub>3</sub> %
M2	54	DPM	18	—	—	24.1	—	18	—	31.5	—
B3	47	DPP	15.2	22.8	150	28.9	127	20.3	89	12.5	55
B4	37	DPP	11.4	12.6	114	27.2	213	7.4	59	—	—
C3	57	DPM	12.1	15.4	127	5.6	36	10.5	68	—	—
B5	45	DPP	14.4	24.3	161	43.5	179	44.5	183	33.2	137
M3	42	DPP	13.5	18.1	134	39	289	36	267	13.4	74
S2	22	DPM	15.6	18.9	121	—	—	30.7	161	41.6	221
S3	45	DPM	16.4	24	146	54.7	228	75.6	315	31	129
		Mean	14.6	19.4	106	31.9	165	30.4	157	27.2	140

with those of  $I_1$  and  $I_3$ , discloses the changes effected by the exposure to anticipation of ECT. Comparison of the later  $I_2$  and  $I_3$  values with those first given for  $I_1$  and  $I_3$  shows the modifications of this difference by meprobamate and by phenobarbital premedication, respectively.

Part 2 consists of two series. Series A (Table 1) presents post-ECT patient values of samples drawn at 30, 75, and 135 minutes after ECT, without premedication, while Series B (Table 1) presents values on the same patients with meprobamate premedication in dosages of 800 mg. orally at 10:00 a.m. and 4:00 p.m. on the day preceeding, and at 8:00 a.m. on the day of, ECT treatment.

The post-ECT experiments of Part 3 (Table 2) were performed as in Part 2, except that different patients were used, and phenobarbital, 30 mg., was employed as premedication instead of meprobamate. The same time intervals for blood sampling were set, but no basal or control studies corresponding to Part 1, Series A, were conducted, since the necessary controls had been obtained in the latter series.

To facilitate comparison, columns of ratios are juxtaposed to their respective columns of values. Changes of 20 per cent were deemed significant.

All ECT was administered with the Medcraft machine, with sufficient current to induce grand mal (in an average of 2 to 4 seconds). Processing of the blood samples and the method of chemical determination for the hormone have been described in another communication.<sup>2</sup>

## RESULTS

### *Pre-ECT Levels and the Effect of Meprobamate*

This study considers columns B and  $I_1$ , of Table 1 and columns B and  $I_3$  of Table 2. The levels in column B, Table 1 ranged from traces\* to 24.6 $\mu$ g. per cent, with a mean of 14.7 $\mu$ g. The individual values were all below 18 $\mu$ g. per cent except for patients F3, C2, and F4, with values respectively of 22.1, 25.7, and 21.4 $\mu$ g. per cent. The eight values of column B in Table 2 ranged from 11.4 to 18 $\mu$ g. per cent with a mean of 14.6 $\mu$ g. Only patient M3 reached the 18 $\mu$ g. level.

\*Traces indicated by "tr" in Table 1. See footnote to Table 1 and comments to follow here.

The 19 values of  $I_1$ , Table 1, and seven values of  $I_3$ , Table 2, were from unmedicated subjects. Nineteen (approximately 74 per cent) showed a rise of from 116 per cent to over 1,720 per cent\* of their respective B values. All but one achieved a change of over 120 per cent. The remaining five, all in Table 1, showed falls, with three sinking to below 80 per cent of their corresponding B values.

Persky<sup>3</sup> has shown that anxious patients manifest a rise in the blood level of hydrocortisone. Their levels were  $13.8 \pm 2.7 \mu\text{g.}$  per cent for normal subjects and  $18 \pm 2.2 \mu\text{g.}$  per cent for anxious subjects. If confirmed by other studies, this level may be termed the minimum anxiety or stress level. Only three of the 28 B values in Tables 1 and 2 attained this level, compared with 12 of the 19 available  $I_1$  or unmedicated pre-ECT values. The mean of the  $I_1$  series was  $23.9 \mu\text{g.}$  per cent. That patients fear ECT has been reported by various workers, one of the latest being Friedman.<sup>4</sup> All 12 patients who showed a rise of blood hydrocortisone above  $18 \mu\text{g.}$  per cent showed signs of distress, such as wringing the hands, clenching fists or even actual crying, as was the case with Patients R1 and R2.

The effect of meprobamate on the pre-ECT hormonal level is seen in the  $I_2$  column in Series B, Table 1. Here, 17 of the 20 values dropped from 22 to 89 per cent of their  $I_1$  levels with only two above 80 per cent of those levels. There were, however, two increases, both significant (R1 and L) both reaching the "anxiety" level. In the 17 values showing a fall, 16 were below this minimum level. Only B3, R1, R2, and L showed signs of pre-ECT distress, all having levels above  $18 \mu\text{g.}$  per cent.

#### *Pre-ECT Levels and the Effect of Phenobarbital*

As will be seen from Table 2, all seven available values were higher than their corresponding B values, and all except B4 were higher by over 120 per cent. Five of these seven had values above the minimum anxiety level. The ranges were 12.6 to  $24.3 \mu\text{g.}$  per cent. Patients B5, B4, and S3 manifested signs of distress. The other four patients showed no such signs, although two of them showed levels slightly over  $18 \mu\text{g.}$  per cent. It thus appears that phenobarbital, at least in this dosage, and given at the times specified, exerts an insignificant effect on pre-ECT anxiety.

\*In the one case where initially a trace of the steroid was determined, an increase in percentage was computed from an initial value of  $1 \mu\text{g.}$

*The Post-ECT Responses, Subjects Unpremedicated and  
After Meprobamate*

The intervals for blood sampling used by Bliss and his colleagues were initial "control," and 15, 60, 120, and 240 minutes after ECT. As early as 15 minutes post-ECT, a rise occurred in most instances, sometimes peaking at that period, sometimes by the sixtieth minute. By the second hour, decline had set in in most instances so that by the fourth hour the level had sunk to below the "control" value. It may be stated parenthetically that the "control" levels in the Bliss series were probably not "basal" in the light of the present authors' work but corresponded to this paper's  $I_1$  and  $I_3$  levels. That is, the Bliss subjects were in the state of fearful anticipation (anxiety?) characterizing the pre-ECT period. In 12 of the 22 Bliss experiments, the levels were  $18\mu\text{g.}$  per cent and above, with a mean of 19.1 and a top value of  $35\mu\text{g.}$  per cent indicating that the adrenocortical mechanism in these 12 cases had already been subjected to some degree of stimulation.

In the present work, the samplings were initial in the controls ( $I_1$ ,  $I_2$ ,  $I_3$ ), and were taken 30, 75, and 135 minutes after ECT, intervals which may be considered as filling in the long gaps between the Bliss samplings. The 30-minute post-ECT value would presumably show the promptness of the response, in some cases the peak, and whatever tendency there was to decline. The 75-minute value should show the peak, and the 135-minute value the duration of the response.

The differences in response between the authors' two series of experiments in which the same set of subjects, were used, Series A unpremedicated and Series B premedicated with meprobamate, can be better appreciated in two summary tables (Tables 3 and 4) rearranged from the values recorded in Table 1.

A comparison of these two tables reveals: (1) In the 30-minute post-ECT period there were more increases in the values in the B Series (19 vs. 11); the peaks being respectively 8 compared to 5; the refractory cases (same as initial) being 0 compared to 3 and the falls 1 compared to 5. (2) In the 75-minute period after ECT, however, the trend was reversed. (3) However, in the 135-minute interval after ECT, there were again more increases in the meprobamate than in the unpremedicated series (6 vs. 3).

Table 3. Summary of Values\* Obtained on Patients in Unpremedicated State Post-ECT Values, Unpremedicated Subjects, Series A

<i>Period changes</i>	<i>Patients</i>	<i>Total</i>
<i>30 minutes</i>		
Increases:	B2, F1, W, B3, E, O, R1, R2, D2, F4, L	11
Increases over 120 per cent of $I_1$ :	F1, W, B3, E, O, R1, D2, L	(8)
Peaks:	F1, B3, R1, R2, L	(5)
Same as $I_1$ :	F2, F3	2
Decreases:	B1, F2, N, M, C1, C2	6
Decreases below 80 per cent:	N	—
Range 11.3-41.8 $\mu$ g. per cent; mean 28.6 $\mu$ g.; S.D. 10.11	Grand Total	19
<i>75 minutes</i>		
Increases over 30' values:	B1, C1, F2, S, W, E, M, F3, O, C2, D2, F4	12
Peaks:	C, F2, S, W, E, M, F3, C2, D2, F4	(10)
Rebounds:	C1	—
Decreases:	B3, N, R1, R2, L	5
Nadirs:	R2	—
Same as 30':	B2, F1	2
Range 19.8-52.4 $\mu$ g. per cent; mean 32.4 $\mu$ g.; S.D. 98.2	Grand Total	19
<i>135 minutes</i>		
Increases:	B1, O, R2	3
Peaks:	B1, O	—
Rebounds:	R2	—
Same during 3 periods:	B2	1
Decreases:	D1, F1, F2, S, W, B3, E, M, F3, N, R1, C2, D2, F4, C1, L	16
Below 80 per cent of $I_1$ :	D1, B3, M, R1, C2, D2, F4, C1	—
Nadirs:	W, S, B3, M, F3, N, F4	(7)
Range 6.4-46.6 $\mu$ g. per cent; mean 23.9 $\mu$ g.; S.D. 10.72	Grand Total	20

\*Values within 1 $\mu$ g. of each other are considered the same. "Rebounds" are rises preceded by a fall. *Italicized* values indicate that they are higher than their corresponding  $I_1$  values.

This suggests that the effect of meprobamate on the response was to make it more prompt and sustained, although an inspection of the absolute values shows that adrenocortical function under meprobamate was generally at a lower level.

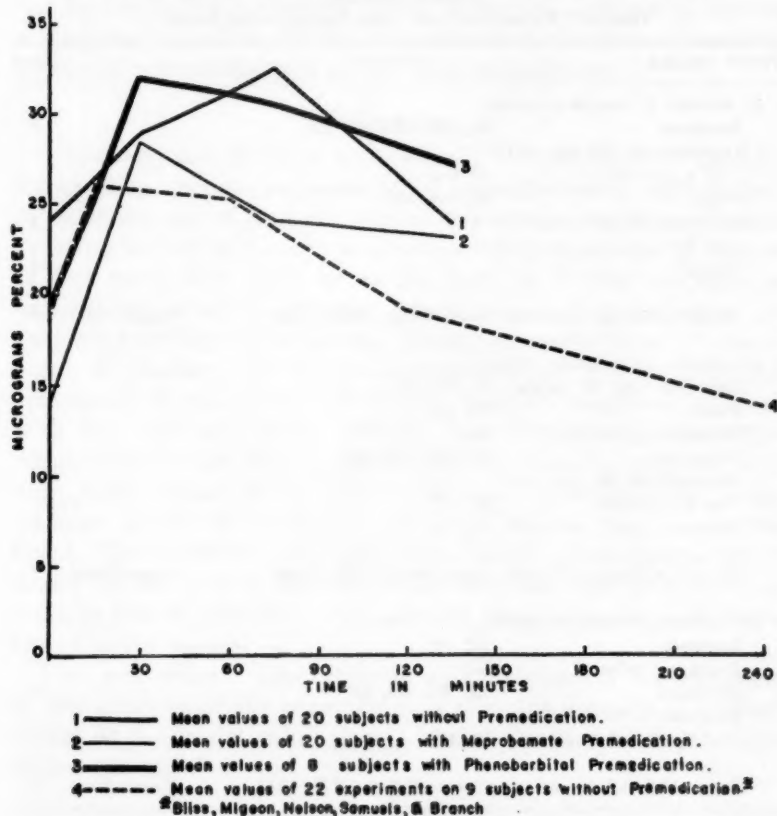
This is shown on the composite chart of mean values in the figure, as well as by a comparison of the "high responders" and the "low responders" in the two series. By "high responders"

Table 4. Summary of Values Obtained on Patients in Premedicated State (Meprobamate)  
Post-ECT Values, Subjects After Meprobamate, Series B

<i>Period Changes</i>	<i>Patients</i>	<i>Total</i>
<i>30 minutes</i>		
Increases	B1, B2, D1, C1, W, F2, B3, E, M, O, F4, N, R1, R2, C2, D2, F3, L	19
Increases over 120 per cent of $I_2$	All except M	
Peaks	W, B3, O, F4, N, F3, R1, L	(8)
Same as $I_2$		0
Decreases	S	1
Nadirs	S	
Range 14.2-48.0 $\mu$ g. per cent; mean 28.3 $\mu$ g.; S.D. 8.01		Grand Total 20
<i>75 minutes</i>		
Increases	B1, B2, F1, F2, S, C2, D2	7
Peaks	B1, B2, F1, F2, R2, C2	(6)
Rebounds	S	1
Same as 30':	D1, F4, W	3
Decreases	B3, E, M, O, F3, N, R1, L, F2	9
Nadirs	M, L (2)	
Range 13.9-41.3 $\mu$ g. per cent; mean 28.3 $\mu$ g.; S.D. 8.01		Grand Total 20
<i>135 minutes</i>		
Increases	C1, S, M, D2, E, L	6
Peaks	M, E, D2	(3)
Rebounds	C1, E, M, L	(4)
Decreases	B1, B2, D1, F1, F2, W, B3, F3, N, R1, R2, C2, F4, O	14
Nadirs	B3, O, N, R1, R2, F4	(5)
Below 80 per cent of $I_2$	B3, O, R1, R2, F4	(5)
Range 4.5-35.6 $\mu$ g. per cent; mean 20.1 $\mu$ g.; S.D. 10.28		Grand Total 20

are meant those with values above 40 $\mu$ g. per cent at any one of the intervals and "low responders" those with values below 15 $\mu$ g. According to this criterion, Series A had 5 "high responders" (F2 with 52 $\mu$ g.; S with 43; W with 53; and B3 with 42) and six "low responders" (B1 with 11.3 $\mu$ g.; D1 with 10.3; E with 14.7; M with 11.8 and 10.6; D2 with 6.4; and F4 with 10.5) while Series B had three "high responders" (O with 48.8 $\mu$ g.; C2 with 44 $\mu$ g.; and D2 with 44 $\mu$ g.) and 10 "low responders" (B with 11.8 $\mu$ g.; B2 with 14.2; B3 with 12.5; M with 14; O with 4.5; F3 with 14.2; N with 10.2; R1 with 12; F4 with 4.8; and L with 11.6).

## COMPOSITE GRAPH OF MEAN HYDROCORTISONE VALUES POST-ECT

*The Post-ECT Responses, Series C Subjects After Phenobarbital*

There are more gaps in the data in this series than the two others, and as stated previously no unpremedicated experiments were performed on the eight patients used. The effect of premedication is shown in the summary table (Table 5).

In the first 30 minutes after ECT, there is thus a rise of 71 per cent of the phenobarbital cases, in comparison with 95 per cent of the meprobamate series and 58 per cent of the unpremedicated series. In the 75-minute period, there is a fall in 50 per cent of the cases, as compared with 45 per cent for meprobamate and 25 per cent for the unpremedicated series, suggesting

Table 5. Summary of Values Obtained on Patients in Premedicated State (Phenobarbital)

Post-ECT Values, Subjects After Phenobarbital, Series C

<i>Period changes</i>	<i>Patients</i>	<i>Total</i>
<i>30 minutes (7 complete values)</i>		
Increases	B3, B5, M3, S3, B4	5
Increases of 120 per cent of $I_3$ or over	all five	
Peaks	B3, B4, M3	(3)
Decreases (36 per cent of $I_3$ )	C3	1
Nadirs		0
Range 5.6-54.7 $\mu$ g. per cent; mean 31.9 $\mu$ g.; S.D. 14.49		Grand Total 6
<i>75 minutes (8 complete values)</i>		
Increases over 30' values	C3, B5, S3	3
Peaks	B5, S3	
Rebounds	C3	
Decreases	M2, E3, B4, M3	4
Decreases to 80 per cent of $I_3$ or under	B4, C3	(2)
Nadirs		0
Range 7.4-75.6 $\mu$ g. per cent; mean 30.4 $\mu$ g.; S.D. 21.69		Grand Total 7
<i>135 minutes (6 complete values)</i>		
Increases	M2, S2	2
Peaks and rebound	M2	
Decreases	B3, B5, M3, S3	4
Decreases to 80 per cent of $I_3$ or under	B3, M3	(2)
Range 12.5-41.6 $\mu$ g. per cent; mean 27.2 $\mu$ g.; S.D. 10.67		Grand Total 6

an earlier tendency to decline. In the 135-minute period, there are falls in 67 per cent of the cases as contrasted with 80 per cent for the unpremedicated and 70 per cent for the meprobamate series. These results would indicate that phenobarbital stands between meprobamate and no premedication in influencing the promptness of adrenocortical response, and shows the highest tendency to decline. However, the composite chart of the mean values in Figure 1, while confirming the promptness of responses, shows the most sustained effect. This is further reinforced by the fact that in this small series of only eight cases, with incomplete data, there were three "high responders" or 38 per cent of the

cases, as compared with 25 per cent for Series A and 15 per cent for Series B. The indication seems to be that, instead of having a suppressive effect on the adrenocortical response, phenobarbital not only accelerates it, but also exaggerates it.

#### COMMENT

The occurrence of "high responders," "low responders" (and by implication, medium responders) of poststimulation depressions, of rebounds, and of straight upward and straight downward trends indicates lack of uniformity in adrenocortical responses. A feature in this work with ECT, as in the work of Persky<sup>3</sup> on anxious patients subjected to stressful interviews, is that responses by subjects with high initial levels, although adequate from the standpoint of absolute values, are definitely much less so from the standpoint of ratio to the initial value, than are responses by those with low starting values. Persky<sup>5</sup> has demonstrated that this comparatively low level of percentile response in subjects with high initial values is not due to adrenocortical deficiency, since infusion of ACTH evokes the expected steroid response in the blood. He vouchsafes no explanation for the phenomenon, but it seems to the writers that both his work and the present work indicate that the function of the adrenal cortex also obeys Wilder's law of initial values.<sup>6</sup>

This law reads: "The intensity and direction of the response of any function of the organism to a stimulus depends to a great extent on the initial value (level) of that function at the moment of the stimulus."

#### SUMMARY AND CONCLUSIONS

1. The levels of hydrocortisone in the peripheral blood of patients awaiting ECT are higher than in the same patients at the same time of the day when no ECT is anticipated.
2. The pre-ECT rise is effectively suppressed by meprobamate premedication.
3. ECT is usually followed by a rise in the hydrocortisone level of the blood, reaching maximum within 75 minutes post-ECT.
4. The effect of meprobamate premedication on the post-ECT pattern of adrenocortical response appears to be one of slight suppression, a slightly more prompt response, and a slight prolongation.

5. The effect of phenobarbital premedication appears also to be a more prompt response, with exaggeration and prolongation of the response.

6. Individual variability in adrenocortical response to ECT was observed.

7. Wilder's law of initial values appears to apply also to adrenocortical function.

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## A MODEL FOR A SOCIOTHERAPEUTIC APPROACH IN THE TREATMENT OF PSYCHOTICS\*

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### I. INTRODUCTION

This paper is an attempt to formulate a model for a treatment approach in the care of psychotic patients and is based upon the experience of the authors at Cleveland (Ohio) State Hospital, a 2,900-bed psychiatric institution. The need to formulate a treatment model arose from the awareness of certain "realities" which, in the opinion of the authors, were operating to negate the efforts of the psychiatric staff. These realities were poor patient-staff ratio, heterogeneity of ward patient composition, and a basically custodial orientation.

The first of these realities—poor patient-staff ratio—is exemplified by the following situation. On the two wards—with a combined patient population of 200—to which one of the writers is assigned, the staff consists of one psychiatrist, one psychologist, one social worker, and five attendants, all on a full-time basis. In addition, a recreation therapist and an occupational therapist are assigned on a part-time basis. While the patient-staff ratio is by no means optimal on these two wards, it is better by far than the ratio on some other wards. It is obvious that such a ratio would tend to prohibit the usual types of intensive face-to-face individual therapeutic procedures, such as individual psychotherapy and casework counseling.

When one analyzes the possibility of the face-to-face individual situation as a ward service, however, the patient-staff ratio is misleading. In the first place, all patients cannot use this kind of psychotherapeutic situation. This is not to assert, for example, that individual psychotherapy cannot benefit all patients. However, it is to say that patients can use psychotherapy more advantageously at one phase in their progress than at another. Furthermore, there is still the possibility that certain patients are just poor risks as far as psychotherapy is concerned. Consequently, at any given time, the possible candidates for psychotherapy would number far, far less than the total ward population. By the same reasoning, occupational and recreational therapies would

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provide the maximum benefits to patients at certain phases in their progress. Thus, the seemingly prohibitive patient-staff ratio, rather than being appallingly discouraging, can be cited to stimulate more efficient use of staff time. The manner of distribution of staff time can be determined only if a theoretical formulation can be developed in which the maximum contributions of each service can be delineated. This formulation must be based upon some conceptualization of the illness of the patient and of the eventual psychological goals for the patient, and must also provide a framework which does not conflict too much with the theoretical formulations which have been developed by each of the disciplines concerned.

The present alternatives—of trying to provide as many services as possible for all of the patients or of selecting certain services for certain patients—leads to many inefficiencies. In the former case, there is very little attempt to fit the therapy to the needs of the patients. In the latter case, all the staff members are required to know all the patients if they are to contribute to a meaningful process of selection. This tends to lead to a dilution of each staff member's knowledge of his patients. If each staff member were required to know and to work with only a part of the patient population, he would be in a better position to become knowledgeable about the patients of his group.

These considerations lead directly into a discussion of the second reality. Although all hospitals are ostensibly established for treatment, the goal or purpose of temporary or long-term confinement and isolation is a moving basis for the functioning of many state hospitals. Thus, while attempts are made to segregate patients and to grade wards in terms of some criteria, these criteria are generally determined by custodial factors, and only secondarily by treatment policies and goals. The primary basis for the differentiation of patients and wards is the goodness or badness of each patient's behavior, the goodness or badness being judged by such qualities as co-operativeness, aggressiveness, noisiness and "pestiness," in contrast to the practice of segregation according to treatment. Consequently, a given ward will have a heterogeneous patient population when viewed from the point of view of treatment but a relatively homogeneous population when viewed behaviorally.

This decreases the possibility of utilizing social atmosphere in treatment, and maximizes the demand that the ward staff, par-

ticularly the attendants, be able to deal with all of the patients at all the various stages of their progress or lack of progress. Furthermore, even for purposes of behavioral homogeneity, the ward structure is poorly defined. Wards are generally classified as "good" or "bad" wards and are not established in such a way as to occupy several points on the good-bad continuum. Transfers of patients are based upon an all-or-none basis so that a patient on a good ward who becomes "bad," that is, assaultive, disturbed, and so on, is transferred to a bad ward. A transfer is seldom made in terms of a treatment rationale and is too often made only on the basis of punishment or custodial demands. Galioni et al.<sup>1</sup> point out that wards have found their functions and identities partly by accident and unguided evolution, partly by being organized to deal with isolated bits of behavior, such as elopement and assaultiveness. They contend that a better alternative is to give wards a character that is determined as much as possible by specialized purposes. This will then lead to the development of personnel skills and to active participation on the part of the patients.

The third reality concerns the nature of the hospital itself. Any psychiatric hospital can be characterized by its purposes and how it goes about fulfilling them. Generally these purposes are curing the patient, protecting the community by isolating the patient, meeting the needs of the patient, educating the personnel and doing research. While lamentable, it seems that the purpose of curing the patient has become secondary to that of protecting the community. This basic orientation has determined to a great extent the kind of physical and psychological environment within which the patient lives, the kind and number of other patients with whom he lives, the kind and number of staff personnel with whom he works, and the kind of rules and regulations which are imposed upon him. In this custodial atmosphere, the attitude of staff member and patient alike is directed toward control and avoidance of tension. When attempts are made to reorganize hospital functions in terms of the primacy of treatment, these have usually met with a great deal of resistance. The usual complaint is that "we didn't do this kind of thing 10 years ago and we had a smooth-running hospital then." The average professional person becomes so frustrated by the resistance that he succumbs to the forces upholding the status quo, withdraws into inactivity

or to an ivory tower, or terminates employment. This succumbing to the forces of the status quo is made palatable by rationalizing the urgency of details and trivia, which in the final analysis merely maintain the old status.

## II. THE PROBLEM

In view of these realities, how can the efficiency of treatment be increased? While all of the realities are obviously interdependent, so that a change in one would effect a change in one or more of the others, which one is most amenable to change? More important, which reality can be changed most economically in terms of time, energy and finances?

The problem of poor patient-staff ratio is more than an economic one. While higher salaries, better facilities and working conditions, would undoubtedly attract more and better staff members, the attractions of such economic and physical factors are limited. The chronicity of the patients' illnesses and the infrequent occurrences of cure or improvement fail to provide sufficient psychological returns for staff members. This is not denying the possibility that better economic and physical conditions will attract more and better people for the staff, resulting in more frequent cures and improvement, which in turn will serve to attract more staff members. Nevertheless, the reality of a general shortage of psychiatric personnel makes it improbable that sufficient personnel can be quickly obtained, whatever the improvement in economic and physical conditions.

The problems of custodial orientation and heterogeneity of ward patient composition, however, are within the action orbit of the individual hospital. Obviously, then, these are the realities which should be the focus of attention.

The quest for redirecting the custodial orientation and for maximizing therapy potential has been directed along two paths, often simultaneously.<sup>2</sup> One is to improve administrative procedures, including supervision, so that matters may be handled efficiently and with dispatch. The other is to select job applicants with more care and provide for in-service training.

The writers submit that these methods, while effective, are limited by the patient-staff ratio and the pattern of psychiatric ideology which has determined staff roles. This pattern has been termed the "psychotherapeutic" orientation by Sharaf and Levin—meeting the needs of the patients, educating the personnel and

son.<sup>3</sup> In this orientation the patient's gaining of insight through a unique, one-to-one psychotherapeutic relationship with a therapist is regarded as the only genuine treatment the hospital provides, and it is implied that the hospital environment serves merely as a benign envelope within which therapy takes place. The implementation of this viewpoint obviously depends upon the existence of a good patient-staff ratio. At the same time this ideology leads to a rather rigid formalization of hierarchy, wherein a sharp distinction is made between therapists and nontherapists. Consequently, a large part of the hospital staff is relegated almost necessarily to custodial roles. A scarcity of therapists then leads either to giving intensive treatment to only a few patients or to a resigned acceptance of inertia.

It would seem, then, that to reduce the custodial orientation and to maximize therapy potential, a different kind of psychiatric ideology is required, an ideology which, the writers suggest, ought to be based on a sociotherapeutic orientation. The sociotherapeutic orientation does not localize the curative agent in any one person or group of persons. Every aspect of the hospital life is considered to be potentially therapeutic.<sup>3</sup>

However, the sociotherapeutic orientation, while distinguishable from the psychotherapeutic orientation in terms of localization of the curative agent, has been infrequently extended to its logical conclusion. Usually adherence to the sociotherapeutic orientation has been limited to the acceptance of the proposition that a given profession does not have the sole ownership of therapeutic potential. Thus, too often, there has occurred a simple substitution of a multi-disciplinary approach for the previous mono-disciplinary one, with each of the disciplines clinging tenaciously to their aspirations to play the traditional role of the psychiatrist.

The traditional psychiatric method views the patient as a discrete individual whose particular constellation of symptoms needs to be analyzed, with a method of treatment prescribed that is consistent with the etiological position. The patient is viewed as a clinical entity and not as a person who is influenced and affected by the network of interpersonal relationships that define the hospital.<sup>2</sup> The sociotherapeutic orientation views as potentially therapeutic not only the formal treatment programs of the hospital and its personnel but also the total social structure of the hospital. The hospital is viewed as a network of personal relationships in

which the patients, who make up a large part of the network, participate socially and share certain values common to that network. The patient's behavior, therefore, is not viewed as solely a function of this individual personality and pathology, but as partly a function of the hospital situation.<sup>2</sup> The social structure of the hospital, then, provides the context and atmosphere, within which and with which both patients and staff interact.

Therefore, the ultimate goal of the sociotherapeutic orientation is to provide procedures, patterns and situations that will facilitate the therapy potential of the hospital, employees and patients by structuring a rationally organized, internally consistent, and treatment-oriented social system. This system must consider the needs, skills and potentials of the staff together with those of the patients.

### III. THEORETICAL FORMULATION

Since this is an attempt to organize a milieu that is therapeutic, some hypotheses about the needs of the patients must first be formulated. Menninger et al.<sup>4</sup> describe mental illness as an impairment in self-regulation wherein devices for coping with emergency are given up because they may produce pain, and a level of functioning which least involves pain is adopted. Mental illness, for the patient, is a way of insuring survival, and optimal adaptation at the least cost. In its effort to insure survival, the ego formulates an organization of its structures and their functions in a manner which can only be described as disorganized from the point of view of mental health.

The therapeutic task then, is to ascertain the degree of disorganization and its course or trend of development, and to delineate the process of organization, disorganization, and reorganization of the personality in a state of attempted adjustment to environmental reality.

If it is assumed that the degree of disorganization is one of the factors that ought to be considered in outlining a rational system of treatment, it would follow that the degree of organization of the milieu ought to be in therapeutic harmony with the degree of ego organization of the patient. It can therefore be hypothesized that, the greater the degree of ego disorganization, the greater is the need for a structured milieu. From this hypothesis, the following specifics are obtained:

1. The greater the degree of ego disorganization, the greater the need for environmental controls; the greater the degree of ego disorganization, the greater the need for a simplified environment.

2. With an abatement of the ego disorganization, there should occur a concomitant decrease in environmental controls; with this abatement of the ego disorganization, there should occur a concomitant increase in the complexity of the environment.

A theoretical basis is yet to be established for the hypothesis that a therapeutic milieu is able to achieve enduring changes in the patient's pattern of interpersonal relations, in his emotional life, and in his personality. Rapaport's discussion of ego autonomy<sup>5</sup> has particular relevance at this point. According to Rapaport, the ego's relative autonomy from drive forces is maintained primarily by the innate apparatus of orientation, of reality testing, and of action, (that is, memory, motor and perceptual apparatus, threshold apparatus, and so on) and secondarily by certain adaptive apparatus, not innate but arising from experience and learning. At the same time, the ego's relative autonomy from the environment is primarily guaranteed by man's constitutionally-given drives and secondarily by cognitive organizations, ego interest, values, ideals, et cetera.

Rapaport's discussion of ego autonomy states that a failure of ego autonomy can result from the following conditions, among others:

1. Fear\* of drives → reduction of the ego's autonomy from the environment and maximization of its autonomy from drives.

2. Fear of environment → also reduction of the ego's autonomy from the environment and maximization of its autonomy from drives.

3. Intensification of drives → reduction of autonomy from drives and maximization of autonomy from environment.

4. Stimulus deprivation → failure of maintenance of structures which are the guarantees of autonomy → reduction of autonomy from drives or environment.

Under the condition of fear of drives and the consequent massive intrapsychic blocking of drives, such as in catatonia, the reduction

\*Rapaport actually refers to massive intrapsychic blocking, as in catatonia. The present authors have taken the liberty of interpreting this defensive measure as resulting from a fear of the drives.

of autonomy from the environment results from the unavailability of the drives, the primary guarantees of autonomy, as well as from the failure of the secondary guarantees of autonomy, such as cognitive organizations, ego interests, and values. Therapeutically, then, the concern would be with decreasing the fear of the drive and with reorganizing and strengthening the secondary guarantees.

Under the condition of fear of environment, and consequent identification with the aggressor-environment, the reduction of autonomy from the environment also results from the failure of primary and secondary guarantees. Therapeutically, the concern would be with decreasing the fearfulness of the environment and with reorganizing and strengthening the secondary guarantees.

Under the condition of intensification of drives, whereby the apparatus have been overwhelmed, the therapeutic concern would be to decrease the drives and/or to reorganize and increase the strength of the adaptive apparatus.

Under the condition of stimulus-deprivation, it is assumed that the patient has experienced, for one reason or another, deprivation of stimuli which are necessary for the development and maintenance of the adaptive structures. Therapeutically, then, the concern would be with providing appropriate stimuli for the development of the adaptive structures.

Decreasing the intensity of the demands of drive or environment would, then, be the first step in therapy. Of relevance to the patient, is his need to be able to control the pressures of drive and environment. In the writers' sociotherapeutic model, the simple, well-structured environment would provide the patient with the support of external controls. Furthermore, this type of environment would tend to deprive the defensive structures which have become part of the patient's pathology of their stimulus-nutrient, and thereby undermine their effectiveness and persistence.

The second step in therapy would be the reorganization and strengthening of the proximal guarantees of ego autonomy—the adaptive apparatus. This would be accomplished by the ever-increasing spectrum of stimuli inherent in the ever-increasing complexity of the environment. The strengthening of the proximal guarantees involves essentially a process of learning in controlled environments.

#### IV. A SUGGESTED MODEL

The following suggested model for a sociotherapeutic approach is based upon the previous discussion, and has, implicit, two purposes. The first is to determine the effectiveness of treatment within a rationally controlled environment wherein the social structure is varied for different degrees of ego disorganization. Patients would be differentiated on the basis of ego organization and placed in units with theoretically appropriate social structures.

The second purpose would be to set up a structure wherein the special skills, bents, attitudes and personality quirks of the staff are used to best advantage in the treatment of psychotic patients.

It would be advisable to reorganize a large hospital, such as Cleveland State Hospital, into relatively small sociotherapeutic units, each with not more than possibly 250 patients as a means of minimizing the problems of communication and co-ordination. Each unit would then be divided into an appropriate number of sub-units. The suggested model consists of five sub-units, but this number need not be final. The criterion would be that the difference between sub-units ought to be definite enough to enable the patient to perceive the differences in role demands for each sub-unit—but without entailing too abrupt differences. The sub-units would be defined in terms of points on an authoritarian-democratic or structured-unstructured continuum, and would offer patients roles ranging from passive reciprocity to active participation.

The first unit, Unit V, might be defined as the highly controlled, simply organized milieu. This unit would have very explicit rules and regulations to which all patients would be expected to adhere. Attendants who exude confidence in their own behavior and therefore are not made anxious or are not neurotic about imposing rules and regulations would staff the unit. The purpose of this unit would be to present the patient with a simple and easily perceivable structure which would serve to give him the support of external controls. This essentially protective and supportive atmosphere would be designed not only to provide external controls for the disorganized ego of the patient but also to provide a reassuring context within which the patient can face previously overwhelming conflicts.

Units IV and III would be defined in terms of increasing relaxation of external controls and increasing demand for decision-

making on the part of the patient. There would be an increase in situations in which self-regulation and self-determination are required. The number of imposed rules and regulations would decrease, with a concomitant increase in the number of situations in which the patient can make his own decisions and thereby increase his ability to manipulate his environment.

The treatment program for Unit IV would revolve around tasks in which a simple manipulation of environmental objects is required. These tasks, while more complex than such tasks as making beds and cleaning the ward, which are required on Unit V, would be primarily task-oriented. Occupational therapy, or similar types of activity, would comprise the primary activity.

Unit III would provide more opportunities for activities requiring interpersonal contacts. Group discussion, group recreation, et cetera, would be the prescribed activities. Here the patient has the opportunity to regain or to acquire new social skills in controlled situations. To encourage the patient to make his own decisions, a self-government structure could be offered. This approach would limit the arbitrary authority of the staff and extend the patient's decision-making role. The activities for this unit would be primarily recreation and group work therapies.

Unit II would be the most highly unstructured unit in terms of hospital-imposed rules, but at the same time, the most highly-structured in terms of social expectations. The patients on this unit would not be bound by hospital rules and regulations to the extent that patients in the other units would be, but would be expected to function as they would in an extra-hospital situation. For example, the Unit II patients might not be told when to get up or when to go to bed, and they might have relatively free access to extrahospital activities and facilities. However, all patients would be expected to be engaged in constructive activities for a reasonable part of the day; they would be expected to make reasonable decisions, to use good judgment, et cetera. In short, the patients on this unit would be expected to function adequately in a situation which is designed to resemble an extrahospital situation insofar as possible—within the limits implicit in the existence of the unit within the hospital.

The purpose of Unit II would be to provide a more easy transition from the hospital to the community. This transition has often been too great for too many patients. Unit II would provide,

essentially, "half-way house" benefits. During this period, the patient would have available the services of vocational and case-work counseling. Psychotherapy could be initiated. The unit program might include activities in which the patients and their relatives could participate jointly, under supervision, so that both patients and relatives could experience situations in which both could receive maximum satisfactions.

Unit I would be the out-patient unit and would follow the patient until his legal discharge. The inclusion of an out-patient unit is the logical extension of the view that the development of the patient from his role as a passive recipient in the hospital to one as an active participant in the total community is an essential aspect of psychological growth. The out-patient unit would provide necessary counseling to the patient and to persons who are directly involved in the patient's health and well-being.

Although theoretically all patients would progress from Unit V through Unit I, some patients may start or end their progress in other units. Or a patient who has progressed from Unit V to Unit IV may be skipped to Unit I, depending upon circumstances. Another patient may be immediately placed on Unit III upon admission and progress from there. The placement and progression of patients would, of course, be a function of staff evaluation of the patients' ego organizations and needs.

#### V. DISCUSSION

The foregoing presentation has been an oversimplified one, and has made no attempt to discuss necessary details, or possible ramifications, of the model. The writers have merely suggested one of many possible models for a sociotherapeutic approach.

The authors are in no position to make valid comparisons between the relative merits of the sociotherapeutic and psychotherapeutic approaches as they might exist in the ideal situation. If there were enough competent psychotherapists to implement the psychotherapeutic approach completely, state hospitals could afford to become treatment centers. In actuality, however, such a condition does not exist, nor does there appear to be any possibility that such a condition will exist in the near future. Consequently, the immediate problem is to establish an orientation which will afford the most efficient use of the present manpower.

The sociotherapeutic approach is suggested as a good remedial measure.

Are the sociotherapeutic and psychotherapeutic orientations mutually exclusive? It has previously been pointed out that the psychotherapeutic orientation tends to rule out the sociotherapeutic approach, but the reverse is not necessarily true. As a matter of fact, it would be the authors' contention that the sociotherapeutic orientation would enhance and abet the processes of psychotherapy. The combination of sociotherapy and psychotherapy would be akin to the concept of "total push," with the basic difference being that in many total push efforts, the emphasis is on bringing the skills of as many professional disciplines as possible to bear on the treatment of the patient, without changing or manipulating the social system within which the total push occurs.

As a final note, the authors feel obliged to recognize that this paper is by no means a finished or adequately polished presentation. They have merely put into writing some of their thinking and their plans for the hospital where they are employed. A unit based on the model presented in this paper has been formed, and it is hoped that some validating data will be obtained soon.

## VI. SUMMARY

This paper has pointed out that because of the poor patient-staff ratio, heterogeneous ward patient composition, and the basically custodial orientation which exist in state hospitals, efficient treatment programs are not possible. This paper has suggested a model for a sociotherapeutic approach which would not only be designed to utilize the skills, attitudes and personality quirks of every member of the staff, professional and nonprofessional, but also provide a social context in which desirable kinds of interpersonal contacts would be fostered. The model provides for a varied number of social structures suitable to the needs of a variety of patients, or suitable for one patient at varying stages in his progress. A theoretical formulation for the sociotherapeutic process, based upon the concept of ego autonomy, was also offered.

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## TRANSFORMATION OF ORAL IMPULSES IN EATING DISORDERS: A CONCEPTUAL APPROACH\*

BY HILDE BRUCH, M.D.

"To tell us that every Species of Things is endow'd with an *occult specifick Quality* by which it acts and produces manifest Effects, *is to tell us nothing*: But to derive two or three general Principles of Motion from Phaenomena, and afterwards to tell us how the Properties and Actions of all corporeal Things follow from those manifest Principles, would be a very great step in Philosophy, though the Causes of these Principles were not yet discover'd."\*\*

These words of Newton are cited by Dingle<sup>1</sup> in an article, "Cosmology and Science," to illustrate the contrast between the old and the new attitudes in scientific thinking. Dingle continues: "What Newton referred to as 'occult qualities' were neatly illustrated by the notions of 'gravity' and 'levity' in the old cosmology: this body fell downward because it was subject to gravity, that body rose upward because it was subject to levity. . . . Neither gravity nor levity had any characteristics by which it could be identified except the movement it was supposed to explain. They were mere names for the phenomena observed, masquerading as causes of those phenomena."

This quotation is cited as a reminder that in spite of our acceptance of scientific principles, psychoanalysis has not completely avoided the error of attributing names to "occult" phenomena and then using these descriptive terms as if they were explanations.

This concern is not new. Freud<sup>2</sup> in 1914, in his paper, "On Narcissism," discussed the difference between a speculative theory and a science based on empirical observations. "The latter [science] will not begrudge to speculation its privilege of a smooth, logically unassailable structure, but will itself be gladly content with nebulous, scarcely imaginable conceptions, which *it hopes to apprehend more clearly in the course of its development, or which it is even prepared to replace by others*. For these ideas are not the basis of the science upon which everything rests: that,

\*From the department of psychiatry, College of Physicians and Surgeons, Columbia University, New York, N. Y. Presented at the monthly meeting of the Association for Psychoanalytic Medicine, February 7, 1961.

\*\*Italics are the present author's.

on the contrary, is *observation* alone. They are not the foundation stone, but the coping of the whole structure, *and they can be replaced and discarded* without damaging it. The same thing is happening in our day in the science of physics, the fundamental notions of which as regards matter, centres of force, attraction, etc., are scarcely less debatable than corresponding ideas in psycho-analysis." (Italics the present author's.)

However, now, nearly 50 years later, it must be admitted that physicists were quite ready to re-evaluate century-old concepts and to discard those that were no longer in agreement with new observations and theories. Psychoanalysts, on the other hand, have been slow and reluctant, even hostile, to the idea of critical reappraisal of their concepts. Serious doubts and disagreement had been expressed concerning the validity of many aspects of Freud's teaching. The revisions have been formulated as new theories, such as Rado's adaptational theory<sup>3</sup> or Sullivan's interpersonal theory,<sup>4</sup> to mention just two, the ones with which the author has become familiar. However, there is agreement with other, tacit or expressed, assumptions, namely the ones which the new theories do not dispute.

In order not to be accused of displaying partiality to one or another American school of psychoanalytic thought, the author chose a British contribution as an illustration of what she has in mind. In 1941, Fairbairn<sup>5</sup> published a revised psychopathology of the psychosis and psychoneurosis, a challenging re-thinking and recasting of the classic libido theory. Guntrip,<sup>6</sup> in 1952, summarized Fairbairn's theory of schizoid reactions and illustrated it with clinical material. Fairbairn's new theory states that the goal of an individual's libido is not pleasure, or merely subjective gratification, but the object itself. The key psychological formula is the relationship of the person to the human environment. This theory of psychosis and neurosis is based on the nature of the relationship of the person with internal bad objects. These "bad objects" are characterized as having resulted from relationships that have miscarried, and thus have become unsatisfactory for realistic experiences. Such an internalized bad object may develop when there is actual loss of a needed person, or loss of a person's love, or when the behavior of such a needed person is interpreted as loss of love. The schizoid and depressive states are considered the two fundamental types of bad-object relationships, with two

basic ways of reacting in the face of frustration, to become angry and enraged and to make aggressive demands or attacks on the bad object—a reaction leading to depression, for it arouses the fear that one's hate will destroy the very person one needs and loves.

But there is an earlier and more basic reaction: "instead of getting angry, simply to go on getting more and more *hungry*, and to react with a longing to get total and complete possession of the love-object and thus no longer be in danger of being left to starve . . . Love made *hungry* is the *schizoid problem*. . . Schizoid aloofness is the fear of loving, lest one's love should destroy."

On the whole, it is a stimulating approach. The present author is concerned with the way the word "hunger" is used in various places. "Instead of reacting with anger, he can react with an enormously aggravated sense of need. Desire becomes *hunger* and *hunger* becomes a greed which is *hunger* grown frightened of loving what it wants." This statement is followed by a clinical example of social withdrawal.

The discussion proceeds: "The entire problem is frequently worked out *over food*." This is followed by an example of compulsive eating: "Whenever her husband comes in she at once feels *hunger* and must eat." This patient says: "'I get desperately tired, and *feel empty inside* and have to buy sweet biscuits and gobble them up.'" (Italics, the present author's.)

Theoretical explanations are given: "Since his basic problems in relation to objects derive from his reactions to the breast, food and eating naturally play a large part in his struggle to solve these problems. His reactions to people and food are basically the same." This may be so, but the discussion and the clinical examples fail to give evidence that these patients had experienced the supposed reactions to the breast during infancy. Nor is there an expression of the need for factual information.

It is this "adultomorphizing" of early behavior, the matter-of-fact tendency of interpreting unknown behavior in terms of adult meaning, that psychoanalysts have tacitly accepted from Freud. Even one who disagrees with the tenet that all psychic events can be reduced to the energy derived from one special instinct will hold that other manifestations of bodily needs have the facility of being freely substituted for an emotional conflict—without raising the question of *how* this is possible.

The problem of understanding the origin of the disturbance of bodily functions in mental disorders has not been overlooked. Kubie<sup>7</sup> examined the interaction between the biogenetic ingredients in the constellation of instinctual derivatives and the symbolic processes. Will,<sup>8</sup> in a clinical paper on human relatedness and the schizophrenic reaction, describes the case of a woman whose illness had begun, many years before, during her adolescence, with loss of appetite and a persistent decline in weight. He refers to the eating difficulty chiefly in terms of its having the quality of nonverbal communication, but adds: "Man describes his living with words, but his perception of his own existence is to a considerable extent governed by the words which he has learned to use." In contrast, Rado<sup>9</sup> postulates an inherited defect, a "proprioceptive diathesis," to account for the distorted body awareness in schizoid and schizophrenic states. The writer's observations on patients suffering from eating disorders cannot be brought into agreement with the unquestioning assumption that early emotional experiences endow a body function with a definite psychological versatility, nor with the relegation of the whole problem to an inborn defect.

All this is in the line of introduction, an attempt to give, not only the general background of the problem, but also the justification for electing the use of everyday language or general medical or psychological expressions here, and deliberate avoidance of psychoanalytic terminology, except in the title. The writer is aware that not using the conventional psychoanalytic vocabulary carries the danger of being misunderstood as iconoclastic, as discarding the dynamic approach, or as offering a simple-minded popular version of a complex topic.

I should like to digress here and make a personal confession. I have the suspicion that my preference for the simplest possible language goes back to some self-observations. When I first began to publish my studies, I made the effort to think and write in English, and on the whole, I succeeded. Yet ever so often, I noticed that I had slipped back into German. I came to recognize that the switch to German occurred whenever the data were not quite sufficient to support a statement, or when the thinking behind it was not quite clear. The German language, with its complicated constructions, and its facility in creating new words, lends itself to expressing involved ideas smoothly and gliding over unclear

meanings, thus creating the impression of great learnedness through many neologisms. When I began to study psychoanalysis, my suspicion of the versatility of the German language was re-awakened by the psychoanalytic vocabulary, which, after all, was invented by a man with unusual linguistic and literary ability in the German language, and with the ambition to be recognized by his nineteenth century fellow-scientists. Freud's style, even when translated into English, reminds me of Victorian "gingerbread" architecture, in contrast to modern functional design and usage.

These, of course, are secondary considerations. The observations that led me to question the validity of the matter-of-factly accepted psychoanalytic terminology and motivational reasoning was a growing disappointment with my efforts to understand and treat a certain group of patients, those suffering from severe disturbance of the eating function. I had been a pediatrician with a special interest in fat children.<sup>10</sup> When I began my study, theories about an endocrine origin of obesity were in vogue. It was an easy step to demonstrate that the then-current endocrine theories were in error. I do not wish to imply that such patients do not have disturbances in their endocrine, metabolic or other biological functions; as a matter of fact, I am convinced that they do have such disturbances, even though they have not yet been identified. The error, during the 1930's, lay in the application of mere endocrine labels which were simply repeated from one doctor to another, without being put to the test of objective validation. The outstanding clinical symptoms, overeating, inactivity and social withdrawal, had either been overlooked or had been blamed on "the glands." It was in the pursuit of the factors leading to obesity and the associated disturbed behavior that I first became interested in the psychological problems of *why* some children developed this way.

It is customary for a pediatrician to see the child patient with a parent. Emotional disturbances of the families were so blatant that an extensive study of the psychological interaction was carried out in 40 families (out of 225). The selection was based on willingness to co-operate, not on the severity of the behavior problems. The findings were published, in detail, in 1940.<sup>11</sup> Although the study had been approached from the angle of the parents, its true focus was on the obese children, and the title "Family Frame" was

chosen to indicate this. The aim of the study was to uncover possible similarities and to recognize the prevailing fundamental trends. No one case corresponded exactly to what was formulated as the composite picture of family interaction in obesity in childhood. A cartoon (Figure 1) illustrates the outstanding findings. The fat child is chained to his mother, who bribes him and appeases, through offering food, his longing to join the fun and play of his peers. The father crouches disapprovingly, but helpless, in the background. If the writer were to design the cartoon today, she would add a "balloon" indicating the child's exaggerated dreams of glory, and some arrows from the mother toward the brain of the child, suggestive of the transmission of distorted concepts and feelings.

This study was done on clinic patients, during the depression years, and many parents were first-generation immigrants. It was recognized from the beginning that this picture needed to be supplemented by studying patients from a higher educational and economic background. Later observations in private practice actu-



Figure 1.

ally showed more similarities in the psychological constellation than had been anticipated; this was in spite of the marked differences in external circumstances. The common underlying psychological problem was the fact that one or both parents looked upon the fat child as a personal possession, something designed to compensate for personal disappointments and frustrations, or to be used as a pawn or ally in unresolved conflicts with the mate. Significant, was the impervious disregard for the individuality and personal needs of the child.

At that time no comparable studies of a whole group of families in relation to one disorder had been published. Psychoanalysts had not yet discovered the need for detailed family observations, which have since become common, even fashionable. The writer has been impressed by certain fundamental similarities in the observations on the families of obese children and those on the families of schizophrenics. This is not really surprising, since a large proportion of the obese children eventually became schizophrenic, whether overtly psychotic or severely schizoid in their adjustments.

Training as a pediatrician was not adequate for studying what went on within the child, for determining how distorted environmental influences could create all the changes observed. The doctor is confronted, not only with the clinical symptoms of obesity, but also with a schizoid picture, a disorientation about the body and its sensations, disturbed self-awareness and social relations. It was with these problems in mind that the writer took up the study of psychiatry and psychoanalysis.

At first it was exciting to uncover the hidden motives and symbolic meaning of the clinical symptoms. It seemed also to be of real help to the patient. As a matter of fact, the writer has become impressed with the ease with which these patients, in particular the obese gifted ones, grasp psychodynamic relationships and acquire an extensive psychoanalytic vocabulary. But they are also notoriously unpredictable and have the ability to improve dramatically, on any regimen, and to relapse just as dramatically. That is what happened repeatedly with the writer's patients and also with those analyzed by others. Increasingly, the writer's practice was made up of patients who had already been in psychoanalytic treatment; some had been reported in the literature as dramatic successes. The relapses and the degrees to which

they had remained unaffected by analysis, appeared more pronounced in obese patients than in other patients who came for additional analytic treatment. Similar difficulties were reported by others. Meyer,<sup>13</sup> for instance, concluded a brilliant discussion of the psychodynamics of anorexia nervosa and bulimia, by stating: "With regard to treatment, I must confess pessimism."

The writer's reaction was to change the focus of inquiry and to look for what was missing in the traditional approach; and this has been done for more than 10 years, with continuous re-evaluation of the findings, in work with obese and anorexic patients in private practice. There was an opportunity to test the revised approach, during the last six years, by supervising residents at the New York State Psychiatric Institute in New York City. They were engaged in the psychotherapy of schizophrenic patients, more than half of whom were young people with severe eating disorders. This permitted the writer to observe patients who were more seriously ill than those seen in private practice, and also to test changing ideas, hypotheses or theories, and the effectiveness of the changed therapeutic approach in collaboration with other psychiatrists.

It gradually became apparent that one implicit error was related to psychoanalysts' exclusive preoccupation with motivations underlying patients' communication and actions. The writer does not dispute that this aspect is an essential part of the therapeutic task, but does feel that there is need for another step, actually a preliminary one, for the understanding and treatment of patients with eating disturbances—and also of schizophrenics in general.

Expressed in the simplest way, these patients, in spite of great differences in their clinical pictures, have an experience in common which they express, explicitly or implicitly, as: "*My mother always knew how I felt.*" Implied is the corollary: "*I do not know what I feel.*" This becomes apparent during treatment when any interpretation, however correct or applicable, carries to the patients a meaning: "There is *someone else* who knows how I feel, and why I do things—but *I* do not know." The great readiness of these patients to acquire psychodynamic knowledge seems to be related to this life-long experience of learning from others how they feel. Yet without genuine experience of feelings of their own, no true improvement takes place. To achieve true improvement, it became necessary to change the therapeutic approach from

a focus on motivation to one on fact-finding, from the inquiry into the *why* of behavior to the question of *how* it had happened that the underlying thinking had developed in this distorted way.

This change-over was not easy. Often the patients were reluctant to give the simpler type of information sought here. Yet in the long run the method proved amazingly effective; and, for many patients, it was the first consistent experience where someone had *listened* to what they had to say and how they had felt, and *did not tell them* what they were supposed to feel, or "what must have happened." In the course of these sober inquiries, it became apparent that many patients used words and concepts, everyday words, not bizarre or schizophrenic expressions, differently from common usage. Over-readiness for interpretation, or stubborn resistance against following the line of an argument, could be traced to such misconceptions or misunderstandings. At times, the writer has called her approach "doing semantics" or detecting "counterfeit communication," or, simply "avoiding clichés."

Along with this change in technique, a re-evaluation of the theoretical considerations was necessary. In the traditional psychoanalytic approach the abnormal food intake is interpreted, according to the symbolic meaning of food and of eating, as a substitute activity in conflict situations. The writer must admit that she is responsible for having started some of these by now widely-popularized notions. The trouble is that such interpretations are not wrong; on the contrary, many additional illustrations could easily be given; the trouble is that they do not really say anything. To go back to the introductory quotation by Newton, this "is to tell us nothing."

In a recent book on anorexia nervosa, Branch and Bliss<sup>13</sup> summarize the current approach by giving a list of the symbolisms of food and body size. Food equals money, love and security, evil, self-indulgence and sexuality, parents, illness, suicide and so on. The writer could add quite a few items of her own. The large, obese body-size is symbolically equated to evil, unhappiness, being sexy, etc., and leanness is equated to being inconspicuous, child-like, or expressing hostility against one's self and others.

One question, among many others, which needs to be understood, is *not for what purpose* food is used in the psychic economy, *but how* it has become possible for a body function to be transformed in such a way that it can be misused in the service of non-nutri-

tional needs. In simpler words: How did the organism learn this trick, or what went wrong in the whole learning process surrounding the satisfaction of nutritional needs? The outcome of such incorrect learning is the inability to recognize distinctly the need to eat, to recognize hunger and its satiation, and to differentiate hunger from signals of body discomfort which have nothing whatsoever to do with the nutritional state "hunger."

Analysts will protest, and apparently with good reason, against the assertion that psychoanalysis has sidestepped this question. The writer has not overlooked Freud's great contribution, the recognition that the way inherent biological needs are satisfied is related to the emotional and mental development. A large part of the theoretical structure of the psychoanalytic edifice is built on the theory of "drives," or on the protest of dissenters against this theory. What the writer wants to say is that this is exactly the field where words have flourished and have taken the place of meaningful explanations. Freud<sup>14</sup> defined instinct as "a borderland concept between the mental and the physical, being both the mental representative of the stimuli emanating from within the organism and penetrating to the mind, and at the same time a measure of the demand made upon the energy of the latter in consequence of its connection with the body." In this form the statement permits the psychic elaboration of many body needs. Freud insisted that the sexual drive was the only one capable of such elaboration. He specifically considered hunger as not suitable for such psychological differentiation.

To any pediatrician who observes, day in and day out, the enormous sensitivity of the feeding situation to psychic influences, such a generalized negative statement must appear debatable; even more so to one who has developed a specialized interest in people suffering from eating disturbances. Nevertheless, the writer tried, until her psychoanalytic experience began to stand in disagreement with this whole type of reasoning. To arrive at a new understanding of how bodily impulses can be transformed, she felt it necessary to construct a much simpler conceptual model, as far as possible without preconceived ideas.

Clinical discussions usually proceed on the assumption that the way body needs are expressed is based on innate biological factors. This is undoubtedly true, but it is not the whole truth. The recognition of body needs and the behavior an organism develops for

their appropriate satisfaction depend to a large extent on learning, from earliest infancy on. The subcortical centers which regulate our visceral and emotional behavior later in life, receive the "information" on how to satisfy bodily needs during the early developmental phases. This fact has been studied by neurophysiologists. Hebb, in *The Organization of Behavior*,<sup>15</sup> summarizing his own observations and those of others, states that lack of food, the state of nutritional deprivation, is apt to be disruptive of behavior. The first effect of lack of food is not an increased directedness and, even in such an animal as the rat, certain learning knowledge must be acquired for appropriate behavior. There are cognitive factors to be considered when "hunger" and also the sensation of "satiation" are studied in the mature animal.

In man with his much more complex cerebral structure, the ways of learning are also more complex. Hebb feels that the non-nutritional aspects of our desire for food are so familiar that they are often forgotten, because they do not fit into the concept of hunger as an innate drive, or of an alternative sensation to the physiological signs of food deprivation. Hunger, defined as the excitation of a neuromechanism that controls eating, is not a simple direct product of the need for food. The writer's clinical observations are in good agreement with Hebb's conclusions.

#### Case 1

To illustrate that actual experiences—not just the vague response to "rejection" or something similar—influence the way a function is established, the writer would like to cite a recent experience, from a consultation on an extremely fat boy, Saul, age 14, height five feet, two inches, and weight nearly 300 pounds. The original information had been that he had "always" been an insatiable eater; later it was said that from about 10 months of age, his desire for food had been without limits. During the baby's first eight months the family had lived in the grandfather's household and the baby had slept in the room of his parents. Since he cried a great deal, the father and grandfather would pick him up, during these early months, and carry him around. When the parents moved to their own apartment, Saul slept in a room of his own. The clinical summary contained the *interpretative* statement that the excessive desire for food had developed in infancy as response to the loss of love and emotional neglect, when the family moved to new quarters and he was removed from his parents' bedroom.

Even though the writer felt that the change in living arrangements during infancy might be significant, she was not satisfied with this inter-

pretation and suggested a more detailed inquiry into the way the feeding had actually taken place.

(The writer is indebted to Mrs. Edith G. Levy, of the psychiatric social service department of the Maryland University Hospital for the detailed information.)

Saul was the third child. The mother had dreaded this pregnancy and had only reluctantly consented to it. In this strictly orthodox Jewish family, her husband and her father-in-law had prevailed upon her because they wanted a male child. The boy weighed only five pounds at birth and refused to feed and would spit up the formula, even while in the hospital. The pattern of spitting and slow feeding continued for several months.

The father was more patient than the mother and he would get up in the night and sit as long as two hours holding the baby and feeding him. When two and a half months old, Saul weighed seven and a half pounds. Even after his feeding improved, he would still need continuous coaxing. When he was three or four months old, the mother developed a backache from which she has suffered recurrently and for which no organic cause has been discovered at any time. The backache made it impossible for her to lean over the crib or to pick the baby up.

From about six or seven months, he was able to sit in a highchair. The mother still could not lift him easily, so he sat for long stretches and would become restless and cry. The mother discovered that she could keep him quiet by sticking a cookie or cracker into his mouth. This would not keep him quiet for very long and the tempo of appeasing him with cookies increased. Saul's weight was normal at eight months, but by 10 months he had become markedly chubby. The mother complained that no amount of food would keep him quiet and as her rate of feeding him increased, so did his weight.

By two years of age he weighed 65 pounds, and he was taken to the Mayo Clinic. He was placed on a 500-calorie diet and he lost weight as long as the diet was adhered to. Then the mother increased the diet from 500 to 1,000 calories because she felt Saul was too weak to carry through. The grandfather, as well as the father, made light of the mother's concern about the baby's rapidly increasing weight, and as Saul grew older he would go to his grandfather's home and the grandfather would cook for him all day long.

Without going into any of the dynamic aspects of this whole family, the importance of which the writer does not underrate, she wishes to point out that the detailed non-interpretative history gives evidence of a grotesquely inappropriate learning experience, that "food" was offered as the great pacifier, a cure-all for whatever discomfort the baby's crying expressed. The mother had felt at all times that this child was "too much"

for her and paid very little attention to him, except for stuffing him with food. This early "programming" of his regulatory centers, as well as that of higher brain function, became his permanent pattern. This "brain washing" occurred at a time when an infant shows the beginning of differentiated perception, cognition, and outward-directed, exploring behavior, to which this mother failed to respond in a discriminating way.

The all-important question is how environmental attitudes and behavior are transformed into learning in the earliest period of life. The writer does not presume to have the answer, but a simplified conceptual model has permitted the making of some relevant observations. In trying to think in terms of observable behavior, instead of introducing adult values and emotional concepts, the writer has come to the conclusion that two basic forms of behavior need to be differentiated: behavior that is *initiated* in the individual, and behavior *in response* to stimuli from the outside. This distinction applies both to the biologic and the social-emotional field, as well as to pleasure-producing or pain-producing states.

Behavior, in relation to the child, can be classified as *stimulating* and *responsive*. The interaction between infant and environment can be rated as *appropriate* or *inappropriate*, depending on whether it serves the survival and development of the organism, or is handicapping or destructive. These elementary distinctions give the dynamic analysis—irrespective of the specific area, or of content—of an amazingly large variety of clinical problems. Similar subdivisions are made in experimental psychology, as *emitted* and *elicited* behavior, and in learning theory as *operative* and *respondent*. Escalona,<sup>16</sup> in her detailed observations of early infantile behavior, uses much the same concepts. She says that a milestone in the course of personality development is the experience that outgoing behavior by the infant, directed toward a person or object in the outer world, finds a response. It is the writer's opinion that environmental responses to clues or signals from the biological field, emitted from the infant from birth on, are the precursors to this significant step in interpersonal development.

The confirmation that there are clues coming from the child is of particular importance for the eating function. When a mother learns to offer food in response to signals indicating nutritional needs, the infant will develop the engram of "hunger" as a sensation distinct from other tensions or needs. However, if the mother's reaction is continuously inappropriate, be it neglectful,

oversolicitous, inhibiting, or indiscriminately permissive, the outcome for the child will be perplexing confusion in his biological clues and later in his perceptions and conceptualizations. When he is older, he will not be able to recognize whether he is hungry or satiated, or suffering from some other discomfort. Such a person needs outer criteria to know when to eat and how much to eat; his inner awareness has not been programmed correctly. As extremes, one finds the grotesquely obese person who is haunted by the fear of starvation,<sup>17</sup> and the emaciated anorexic who is oblivious to the pains of hunger and the weakness, fatigue and other symptoms of chronic undernutrition.

In less conspicuous situations, one is not likely to recognize this mechanism unless it is systematically looked for. Many patients will answer a question about it with an immediate sense of recognition that precisely what they have been suffering from all their lives is that they have never known when to stop eating except by being told or by observing polite behavior. Their cognitive perception of their own nutritional state is inaccurate. Stunkard,<sup>18</sup> in experimental work, observed the same phenomenon, which he attributed to a denial of hunger sensations in the face of social disapproval.

Nutrition, of course, is not the only function that is misperceived and misused in this way. There are usually difficulties in identifying other bodily sensations and in recognizing emotions and appraising interpersonal situations. Disturbances in eating, reflected in the changed body size, label the most conspicuous symptom. Incorrect conceptualization of body states has also been recognized in homosexuality, tic-syndromes, phobias, and other conditions.

Correct or incorrect learning experiences are codified in the brain on various levels of conceptual representation, depending on the stage of brain maturation. The learning process is not restricted to infancy, but is continuous through childhood. Our ordinary, adult eating-behavior, with all its refinements of taste and manners, is a function of higher levels of brain activity. In situations of emotional stress, these late-acquired, conventional habits may give way to earlier patterns, and will result in serious disturbances if these more basic patterns were incorrectly laid down.

In patients in whom eating disorders developed to a conspicuous degree early in life, the writer has invariably observed serious

disturbances in adaptive capacity and personality development, and a close relationship in personality characteristics to schizophrenia. Detailed histories reveal that many other activities than eating initiated by the child, had been inappropriately responded to or disregarded. The same type of mother who will find a child's body needs according to her own preconceived ideas or impulses, without attention to what the child really needs, is also handicapped in responding to other facets of child-initiated behavior. In the family studies on schizophrenics, the mother's attitude toward the child is frequently described as "impervious."

Such a mother does not neglect her child; on the contrary, she may be very busy with him, in an effort to *make* him do the things *she* feels he should do. In extreme situations, where the mother in a one-sided way *only superimposes* on the child what corresponds to *her own* emotional or bodily state, and the impulses originating in the child are completely disregarded, the child will grow up without a sense of identity. He will live almost exclusively by responding to others, whether with overcompliance or rigid negativism, but without experiencing the sense that thoughts, feelings, or actions originating within him can be effective—or anything else but evil.

One may recognize that what has been described here is the essential matrix of schizophrenic development, where—in the most severe cases—there is the sense that someone else is directing feeling and thinking, and there is only the dimmest concept of self-identity and body awareness. The disturbances in body concept, including the falsified awareness of proprioceptor impulses, seem to represent the link between the severe eating-disorders and schizophrenia, where conceptual disturbances are more conspicuous.

It may sound too sweeping to consider the disregard or nonconfirmation of emitted behavior of such crucial importance. The writer found unexpected support for this view in experimental work that has attracted wide attention in recent years. This is Harlow's study of what he calls "affectional systems" in monkeys. He raised infant monkeys to maturity in an ingenious set-up where they had free access to a clutchable wire-covered or cloth-covered dummy, referred to as "mother." Harlow's early publication<sup>10</sup> indicates that he felt that the monkeys who had a cloth dummy available, on which they could "rub in mother love" (his

expression) were more secure and more capable of affection than those raised with wire dummy mothers. The present writer's reaction to the early report was that if these monkeys were human infants, they would become schizophrenic. The monkeys are now fully grown and, to Harlow's surprise, have become neurotic, apathetic, stereotyped in their responses, suffering from abiding affectional deficiency, incapable of grooming behavior, and inadequate in sex behavior, though having undergone physiologic puberty. Harlow has named the condition "non-social syndrome."<sup>20</sup> In the present writer's analysis, the outstanding aspect of the experimental design was the *absence* of response, confirming, reinforcing or inhibiting, from a live mother monkey to behavior initiated by the infant. This means that these infant monkeys had been deprived of learning experiences essential for the organization of usable and adaptable behavior.

Thus far, the discussion has focused on the way that inappropriate interaction between mother and child results in a falsified foundation for his perceiving his own bodily states. The questions remain about how these early distortions influence the child's later conceptual and symbolic organization of his experiences, and how they can be recognized. Recently, Bateson and his co-workers<sup>21</sup> proposed a model to account for the confused thinking of the schizophrenic, based on the theory of logical types of Bertrand Russell, and on communication theory. This model, under the name of "double-bind," has become so familiar that it is not necessary to go into any details of it. Valuable as this theory has been in the attempt to associate early influences with the later disorder in thinking, it does not take into account the changing conceptual forms available to the child for structuring these confusing messages of his perceptions, including those originating within his body.

In the key example of Bateson, the child was enmeshed in a situation where the mother called him "tired." The child was trapped between the painful alternatives of recognizing his mother's lack of love, or of denying the evidence of his own senses. The writer's comment would be that under circumstances of repeated "double-bind" situations, a child would probably be unable to discriminate between the sensations of physiologic fatigue and wakefulness.

The early conceptual and symbolic structures, and the sequence in which they mature in the child, have been studied and described in detail by Piaget.<sup>22, 23</sup> Between 18 months and two years, the normal child becomes able to manipulate objects, and symbols for objects, and relationships between objects. The earlier phases of the development, before the infant's brain has reached the maturity necessary for abstract thinking in words or symbols, are important for setting the stage for the later developmental phases. The ability to experience his body sensations appropriately is an important preliminary step. During these earliest phases of pre-symbolic conceptualization, the child has to construct the whole framework for later experiences; in particular he must establish the Kantian categories of Time and Space.

The child learns to realize space as a conceptual entity. Only after this task has been accomplished can he begin to differentiate himself as distinct from objects on the outside. The relationships through which he organizes his conceptions of these objects have been found to have the properties of relationships in topological space. (Topological space stands in contrast to geometrical space which becomes a usable symbol only much later.) These are the properties of figures which are conserved through any deformation which contains the singleness of the figure: that is, relationships of closeness and distance, separation, sequence, continuity, and enclosure. These relationships permit the child to recognize objects in his sensory field without an understanding of perspective and geometry.

The important part of these theoretical observations by Piaget is that they give some basis for the time to expect that a child will first become able to separate sensations arising within his body from those impinging from outside. As Kubie<sup>24</sup> has pointed out, he learns that there are groupings of sensations which are preserved despite their various displacements in his perceptual field, and thus learns to regard his own body as one of these groupings.

An essential aspect of this development is the child's ability to identify his bodily urges on the one hand and his viewing, comfort-feeling or discomfort-feeling "self" on the other. He learns to think of body and self as occupying the same space and forming a single functional unit, separate from the units around him. If, as under the situation described before, confirmation and reinforcement of his own sensation has been missing or inaccurate, then the child

will be perplexed when trying to differentiate between disturbances in his biological field and emotional experiences, and will misinterpret the latter as deformities in the spatial configuration of his self-body concept.

Distortions of body image and defects of ego boundary have been described as characteristic of schizophrenic development. Body image has been variously defined but emphasis has been chiefly on sensory perceptions, coming from the skeletomuscular system and the surface of the body. Kolb<sup>25</sup> suggested recently the need to include other sensory perceptions, including sensations coming from the inside of the body; and he suggested the term "body concept." The writer's observations are in line with these suggestions. They are that distortion of the stimuli coming from the inside of the body may result in serious disturbances of body concept. If the falsification of body awareness is severe, a person may feel that he *neither owns his body nor is in control* of its functions. Patients suffering from eating compulsion will say: "*It just happens to me—I do not want to eat.*" There is an over-all lack of awareness of living one's own life, a conviction of the ineffectiveness of all efforts and strivings.

Disturbed self-differentiation expresses itself in many ways. Drawings of the human figure have been found useful for the study of body image. In addition to this, the writer has raised the question whether the *language*, our most flexible tool of self-expression and communication, contained evidence of the deformed self-image. In collaboration with Palombo, she examined the speech samples of schizophrenic patients in the recovery phase, at a time when they appeared to be realistic and coherent. It was observed that they frequently used images of a peculiar spatial character.<sup>26, 27</sup>

This spatial imagery was employed when describing feelings of isolation and abandonment in respect to people, and feelings of dissociation in space between their bodies and self-awareness. The images ranged from innocuous everyday figures of speech to strange, more private, formulations. Sometimes even ordinary spatial expressions conveyed a certain concreteness of meaning. The writers concluded that these spatial clusters were like anachronisms in the adult speech, indicating disturbances during the earliest period of conceptual development, when, according to Piaget, the child utilizes spatial relationships for the conceptual construction of reality, the outer world, and his own place in it.

It seems that when essential information and validation from the environment is absent or misleading, unrealistic conceptions of the spatial relationships are formulated, resulting in poorly differentiated concepts of the outer world, and of one's own mental faculties and body awareness. Even in the absence of manifest clinical symptoms, the use of spatial imagery in this clustered way is a signpost that basic problems of self-differentiation have not been solved successfully.

### Case 2

As illustration, a few examples will be given of how disturbed self-representation is reflected in the speech and art work of a young woman, "Sue," who was a patient at the New York State Psychiatric Institute, from June 1958 to October 1959. She was treated, in intensive psychotherapy, by Dr. Richard A. Gardner. There were many joint interviews with the patient and her mother.

The outstanding clinical findings are summarized in her weight chart (Figure 2) with its enormous ups and downs. The lowest point, at the age of 16, was 74 pounds, and the highest was 174 pounds, on admission to the hospital. Between the ages of 13 and 20, she gained and lost nearly 530 pounds. This was associated with drastic changes in her food intake and eating habits. Treatment efforts, medical as well as psychiatric, extend-

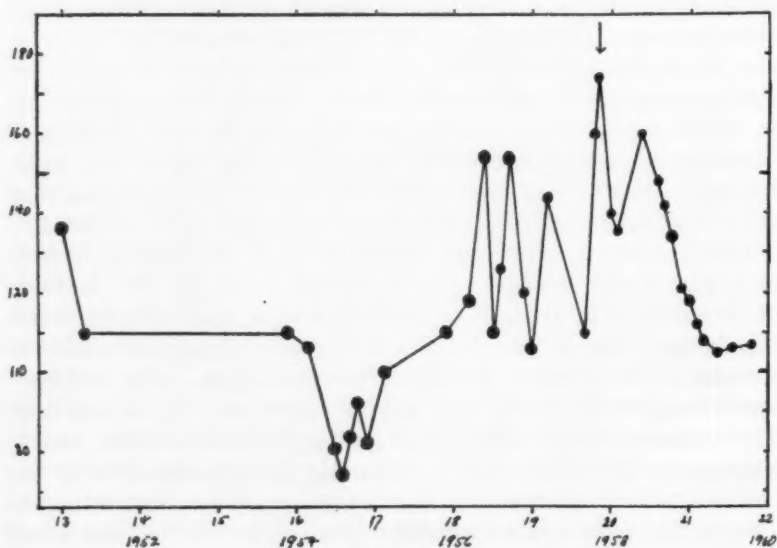


Figure 2.

ing over several years, had not affected the essential problem of this girl, in particular the eating-and-starvation compulsion. While at the hospital the weight fluctuation continued, but the second period of loss was slower and food intake appeared to be more controlled. Repeated inquiries into her awareness of her body state revealed that at no time could she describe a sensation that might be called hunger, nor did she act at any time like a person who was exhausted by undernutrition.

Sue was the oldest of three girls of a Jewish family. Both parents protested in a frantic way that theirs was an exceedingly happy home, particularly denying the reality of their daughter's unhappy state. The mother summarized the loving and devoted climate as perpetuated within her family: "My mother always *anticipated* my wants—and that's what I want to do for my daughters." This "anticipation" had taken the form of forcefeeding if Sue did not eat everything the mother wanted her to eat, frequent enemas, emphasis on perfect cleanliness and what one might call "training in exhibitionism." Sue expressed herself as: "I hate her for giving birth to me. I know she wants me to be perfect. When she says I am perfect, she is really saying that she is perfect by giving birth to me and making me perfect." At another time: "She is me and I am her; does she love me or does she love her [self]...? I might be destroying my mother; I identify myself with my mother, by destroying myself I destroy my mother also."

Sue was one of the patients included in the language study. Even before the systematic study was carried out, certain aspects of her speech pattern had aroused attention. During a conference, in which she was interviewed with her parents, she had kept a rigid posture. She explained later that she had done so because she felt she needed to keep herself all together in an attempt not to lose her identity: "I felt like I was in a shell and if I moved too much, I would crack out and then I would get hurt."

There also was occasion, in the joint conferences with her mother, to recognize Sue's reaction, by reveries, to the mother's domineering expressions. In a half-defensive but also in a self-aggrandizing way, the mother described how *she* had *made* her husband from a nobody into a big shot. "There is his brother in the Bronx and his sister and her husband, and they want to think little of him, but as *my* husband, they had to think he was a *BIG MAN*. That's exactly what he was (little). I was unhappy about this and *I had* to teach him."

After many details, she turned to her daughter, asking: "And how did you feel about what I just said?" The daughter had been staring into space, seemingly inattentive. "You talk so much. I just sit by and dream. I pick up a word now and then—and get mental images."

She added: "I thought of a three-ring circus in the way she builds my father up. I get the image of a poor little animal in a cage, standing by the bars, and then she comes over and batters down the cage and drags him into the arena and puts him into the middle of everything and shouts, 'Here is the leader.' And the poor little animal stands there and says, 'Oh, I don't want to be the leader, I don't want to be the leader.' But the attitude is that you *have* to be it *now*, and he wants to run away. I was not thinking of myself, about the circus, I was only thinking about my father."

Usually the spatial imagery is less picturesque, more interwoven in the ordinary speech pattern. To quote from the speech sample which was analyzed in detail for the study: "I'm always making these little *straggling* attempts to *contact* people, to *get along* with people, *reach out* for people in hours of need. Only to either *reject* them or to be *rejected*." Or later, "I know that I *fluctuate between* being extremely domineering and *between* being a *leaner*, the one who needs *direction* and needs, what's the word, incentive, somebody who has the *get-up-and-go*."

There would be nothing conspicuous about this usage, except that it occurred in the speech sample only when Sue discussed her discomfort in relation to people. It could have been expressed without spatial imagery: "I make weak efforts to learn to know people and to be friendly with them, or try to be intimate with someone when I am unhappy. But I do it only to be able to show I dislike them. . . . I know that I change from being domineering to looking for help, the one who needs to be told what to do. The one who needs encouragement by somebody who has the energy to know how to do things for himself."

Finally, one may point to a few of her paintings done during the early part of her hospitalization. She had no previous experience in art and was encouraged to experiment. She began with charcoal but soon decided on oil, which she used in flat solid areas, and in strikingly brilliant colors.

She felt strongly identified with her art work, spoke of each painting as "part of me." The O.T. workers noted that she usually wore an outfit with the same colors she was going to use in the day's painting. She objected when her paintings, after they had become too numerous to be kept on the shelf in the art shop, were placed in a closet, and reacted as if she had been personally injured.

At first she produced only distorted faces, with nothing below the chin. Relating to herself, she described a painting with a double profile: "My conflict, my schizophrenia, I become like two different people, acting one day to the next."

When she began to paint figures, she produced in the beginning only heads with long necks and bulbous bodies, without limbs. She gave vivid

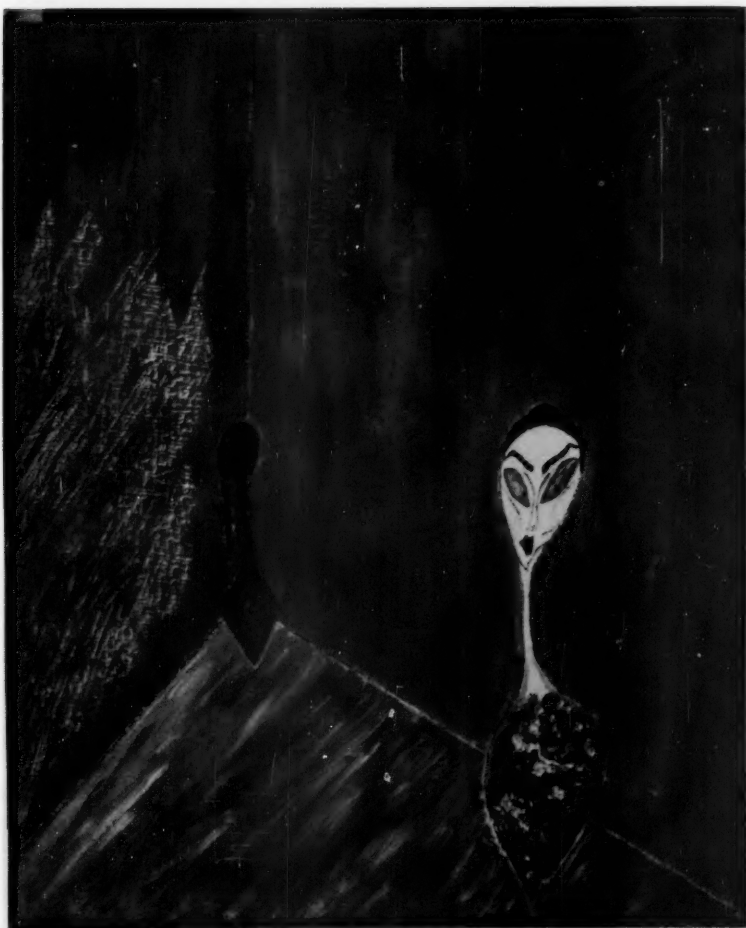


Figure 3.



Figure 4.

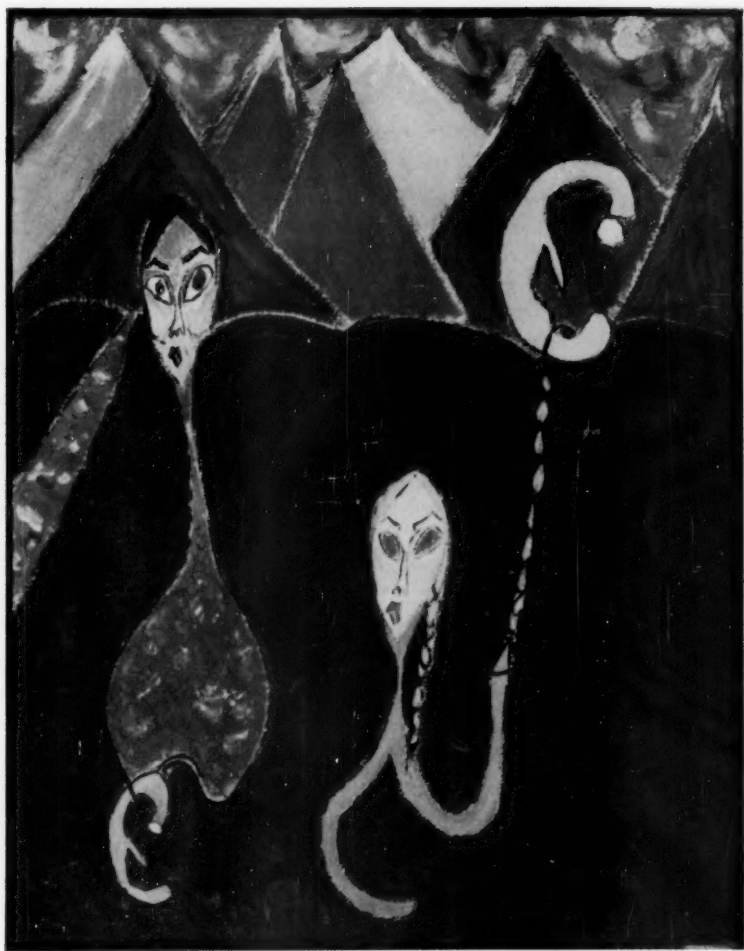


Figure 5.



theatrical names to all her paintings. Her favorite was called "*The Rejection*," (Figure 3) a scene recalled from her childhood. In colors the mother's dominance was even more pronounced; she was done in brilliant colors and the forlorn child in the corner in a drab dark blue.

The only male figure appears in a painting called "*The Promise*" (Figure 4). This was painted while she was involved in a rather intense romance. "They are joined by his arm. All women are empty, waiting to be filled. My own feelings of emptiness—the eating me—the site where I get the sensation prior to eating and when I get anxious. . ."

The next painting, several weeks later, was called "*Emergence*." It contains three figures of which she said, "They represent myself." This picture contains the first full figure of a woman with pointed breasts: "this is youth—energy; nothing sags." The final picture of the series, "*Prenatal Carnival*" (Figure 5) represents an outdoor scene, and it was the most colorful painting of the series. "The mother carries a fetus on her arm like a pocketbook." A fetus also replaces the balloon that the child carries on a string. "Although the child grows, the mother still carries the remembrance of her child in her arms." Though close, the child is separate from the shadowy fetus the mother still carries. The child is more playful and free than any of the previous figures, and the hollowing body is opened into independent arms.

#### CONCLUSION

Talking about speech patterns and art expression may sound a far cry from the transformation of oral impulses. The connection lies in the disturbed interaction between the organism and its environment which results in distorted functioning of conceptual thinking and body awareness. Failure of appropriate response to signs and signals originating in the child has been singled out as the outstanding deficiency in the transmission of information that is essential for learning to identify body states correctly. Thus the organism acquires inadequate building stones, which can be recognized in the distortions of the subsequent symbol and concept formation. The individual is equipped with inadequate tools for self-orientation and identity, and the widening demands of self-expression and interpersonal experiences. The whole gamut of disturbed behavior, manifest as clinical symptoms, and the variety of motivational defense mechanisms, with which psychoanalysts usually concern themselves, must be considered as secondary to this basic deficiency. This conclusion was arrived at in working with schizophrenics and with patients suffering from

eating disorders. The writer is aware that the theoretical model presented is applicable to basic conceptions of mental functioning and personality development, on a wider scale.

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## THE USE OF GLUCAGON IN INSULIN COMA THERAPY\*

BY BENJAMIN BLACKMAN, M.D.

The introduction of glucagon into clinical medicine has been the result of many years of research and has now proved to be a significant step forward in the termination of insulin coma therapy. The early methods of termination included the use of intravenous medications and gastric lavages. The intravenous route often resulted in subcutaneous infiltrations, venous thromboses and unsightly bruises at the site of injection. The tube feedings produced nasopharyngeal irritations and entailed the daily risk of accidental tracheobronchial intubation and infection.

All of these undesirable effects have been replaced by the simple procedure of injecting 2-4 mg. of glucagon hypodermically when termination of the insulin coma is desired. The patient awakens in a few moments and is soon able to eat breakfast comfortably and easily. The method has been shown to be effective, reliable and safe.

### HISTORY

The history of the origin and development of glucagon is especially fascinating because it was developed primarily in laboratories devoted to basic medical research. The research workers were mainly concerned with the elucidation of its physiological properties and chemical characteristics. That their studies might lead to some clinical usefulness could only be hoped for, and that the first group of patients to benefit should be in the field of mental illness could hardly have been realized during these years of research. Nevertheless, their efforts led to the discovery of a new drug and demonstrated once again the applicability of fundamental research to the improvement of medical care.

As early as 1923, Murlin et al.<sup>1</sup> reported that an acetone precipitation of pancreatic extract had "power to act in just the opposite way to insulin; namely, to raise the blood sugar both of normal and diabetic animals enormously." Murlin named this hyperglycemic factor "glucagon."

The further development of glucagon remained static for many years, in fact until 1948, when Sutherland and deDuve<sup>2</sup> theorized

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that the hyperglycemic-glycogenolytic factor of which Murlin spoke might be a "contaminant" of insulin. Thus, after years of study at the Eli Lilly Research Laboratories, glucagon was crystallized in 1953<sup>3</sup> and its chemical structure delineated in 1957.<sup>4</sup>

Early chemical studies of glucagon suggested that it might be a breakdown product of insulin. However, following the crystallization of glucagon, it became apparent that it was an entirely different substance from insulin—one which contained no cystine, proline or isoleucine. Methionine and tryptophane were found to be present.

The isolation and crystallization of glucagon clarified the earlier problem of an initial hyperglycemic response when commercial insulin of United States origin was injected intravenously. Danish supplies of insulin had produced no such hyperglycemic effect and had stimulated the investigation which later demonstrated that the rise in blood sugar was due to a "contaminant," i.e., glucagon, which could be isolated and removed from commercial preparations of insulin so as not to "antagonize" insulin's therapeutic effectiveness.

It is exciting to read how the careful study of this "contaminant" gradually led workers to discover that glucagon was a hormone *sui generis*, which had chemical properties and physiological potency of its own, as well as possibilities for use as a therapeutic agent. Indeed, with the advent of purer preparations of glucagon, it became possible to experiment in cases which required hyperglycemic effects. Because insulin coma therapy requires just this, experimentation was begun in this area and a much smoother and simpler technique of coma termination was developed.

#### TECHNIQUE OF ADMINISTRATION

The technique of the administration of glucagon is exceedingly simple. One need only inject the hormone hypodermically about 10 or 20 minutes before the complete awakening of the patient is desired. Thus, if it is desired that patients be awakened by 11 a.m., the nurses are instructed to administer the glucagon at 10:45 a.m. The patient awakens smoothly and comfortably. Since his stomach has not been filled with materials from a gastric lavage, he is able to eat breakfast on an empty stomach. The writer, therefore, has had few complaints of nausea and only one instance of vomiting following this procedure.

## SUMMARY OF RESULTS

The writer has now terminated over 739 insulin comas with the use of glucagon. A majority of these had reached the third or fourth stage as classified by Himwich,<sup>5</sup> although some patients had achieved only the second level at the time of termination. Since an effort is made to terminate the treatment before the fifth stage is reached, only 17 of the comas were terminated at this stage, but each of the patients concerned recovered nicely in the usual period of time and with no unpleasant side effects.

Table 1 indicates the number of comas which were terminated in stages II, III, IV and V.

Table 1.

Stage	Number of Terminations
II. ....	79
III. ....	185
IV. ....	458
V. ....	17

## DOSAGE

Glucagon is now available in its crystalline form and is readily soluble in a solution of glycerin 1.6 per cent with phenol 0.2 per cent added as a preservative. The final mixture contains 1 mg. of glucagon per cc. of solution and is, therefore, a convenient preparation for measuring dosage.

The author's experience with the effective dosage of glucagon for the termination of these comas suggests that the optimal one is about 2 mg. On occasion, it has been found necessary to administer an added dose of 1 mg. to patients who did not seem to clear completely with the 2 mg. dose. In addition, there were many who could be terminated smoothly and comfortably with as little as 1 mg. Table 2 gives a summary of these results.

Table 2.

Dosage	Number of Terminations
1 mg. ....	49
2 mg. ....	568
3 mg. ....	92
4 mg. ....	28
5 mg. ....	4

The writer has tried to administer the minimum amount of medication necessary to achieve a prompt and complete termination of the coma. The present procedure is to begin with a dosage of 3 mg. for three days, and, if this is effective, reduce it to a

dosage of 2 mg. for three days. Depending upon the patient's response, one may then try the patient with 1 mg., maintain a 2 mg. dosage or return to the 3 mg. level. Since different patients need varying amounts, this flexible procedure has been found most efficient.

#### SIDE EFFECTS

Side effects from this procedure have been rare and are easily treated. A few instances of secondary insulin reactions have occurred later in the day, but these responded promptly to an intravenous administration of 50 cc. of 50 per cent glucose. On two occasions, the writer had patients who developed a delayed coma. Additional quantities of glucagon were administered, as well as intravenous sugar. Muscular spasms followed for a period of one day in one patient, and two days in a second. These spasms cleared completely. They were associated with EEG changes which also cleared completely within a week. Further insulin treatments have not been resumed with these patients, and they have suffered no untoward effects since that time.

It should be pointed out that the side effects mentioned occurred from time to time with earlier methods of termination and undoubtedly represent side effects of the entire coma treatment rather than effects of the glucagon *per se*.

#### ADVANTAGES

The advantages of this technique far outweigh those of the earlier method. The unsightly bruised areas after intravenous injections of glucose are no longer seen. Painful subcutaneous infiltrations have been obviated. There is no longer any need for risking an accidental tracheal insertion of the tube during a gastric lavage.

Nurses have been able to spend more time relating to patients rather than preparing the intravenous and gastric medications. This has improved the entire milieu surrounding the termination of each treatment. The training of student nurses for insulin coma therapy has become simpler and the risks of complications have been reduced accordingly.

#### SUMMARY

The use of glucagon in the termination of insulin coma therapy has been discussed. The advantages over previous techniques of

termination were described. Clinical experience with 41 patients who had a total of 739 comas showed no untoward reactions with the use of glucagon. No permanent residual effects were noted, and only transitory reactions, such as delayed coma, muscular twitching and secondary comas were reported in six instances.

It has been demonstrated that glucagon is an effective, reliable and safe drug in the termination of insulin coma therapy. Its introduction as a therapeutic agent has demonstrated once more the many benefits which can be derived from basic medical research.\*

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## THE APPLICATION OF PSYCHODYNAMIC THINKING TO HYPNOTIC BEHAVIOR\*

BY LAWRENCE J. BOOKBINDER, Ph.D.

The application of hypnotic techniques in psychotherapy is limited today to a small minority of psychotherapists. This is, here, considered to be unfortunate because it may be assumed that the broader a therapist's repertoire of techniques, the greater the probability of his helping his patients. (See Wolberg,<sup>1</sup> for example.) It seems probable that the major reason for the limited use of hypnotic techniques is that therapists who employ hypnosis have different conceptions of its utilization and effects, as compared with therapists who do not use it in their practices. This paper will take some opening steps toward reducing these differences in concept, by discussing the phenomenon of hypnosis itself, apart from its uses as a therapeutic tool. The aim is to accomplish this by discussing hypnotic behavior in such a manner that it will be meaningful to therapists of a dynamic orientation, regardless of whether they utilize hypnotic techniques or do not.

### CONCEPTS AND PSYCHODYNAMIC ORIENTATION

For the purpose of agreement on what is meant here by concepts, some of these will be briefly defined. *Hypnosis* is an altered condition of consciousness<sup>2</sup> or of ego functioning<sup>3</sup> which is induced by psychological means; just exactly what the alteration is, is a matter that is currently only at the speculative stage, but this fact is not important for the purposes of this paper. *Hypnotizability* is the ease with which a patient can be hypnotized or have his state of consciousness altered; it is influenced by many variables, but this paper will focus only on the psychodynamic ones. These *psychodynamic variables* will refer to the patient's personality structure, his needs, and his conscious and unconscious perceptions of himself and his relationship with the operator (hypnotist). *Hypnotic behavior* will refer both to the process of hypnotic induction and to behavior after induction. This latter category in-

\*From the Ann Arbor Veterans Administration Hospital. The writer would like to thank Drs. Albert I. Rabin, E. Lowell Kelly, and Melvin Manis for their helpful suggestions. However, it should be noted that the responsibility for the contents of this paper rests solely with the writer; also, the contents do not necessarily represent the opinions or policy of the Veterans Administration.

cludes the various phenomena associated with behavior during hypnosis, depth of hypnosis, termination of hypnosis, and post-hypnotic behavior.

The psychodynamic variables related to hypnotic induction are deemed important because of the assumption that a patient will more readily allow an operator to alter his state of consciousness if he feels secure with that operator, or if some of his emotional needs can be gratified in the hypnotic relationship. One implication of this is that a utilization of psychodynamic thinking may contribute to hypnotic-induction procedures, because the security or need-gratification derived by the patient is based on unconscious, as well as on conscious, factors.

Not only do psychodynamic variables affect the induction of hypnosis, they also affect behavior after induction. This is what Watkins<sup>4</sup> means when he states that "...trance and transference are the same." To be more specific, he is referring to the phenomenon that the manner in which a person enters into or behaves during a hypnotic relationship is indicative of his transference attitudes, that is, of his past relationships with significant people in his life. One implication of Watkins' statement is that different operators will elicit different behavior from the same hypnotized patient. Another implication is that the same patient may relate differently to the same operator in different sessions—just as in the psychotherapeutic situation, transference attitudes or ego states may fluctuate from session to session.

There are still other reasons why viewing hypnotic behavior from a dynamic point of view can be useful: (a) The dynamic approach is a common meeting ground for many therapists, including some who use hypnosis in psychotherapy as well as some who do not. (b) Appreciation of the significance of dynamic factors in hypnosis may make un hypnotizable patients more accessible to hypnotic techniques. That is, if these patients are viewed as having some sort of psychological resistance to induction, it is psychodynamically reasonable to expect that, if this resistance can be worked through, it will increase the probability of hypnotizing the patient. (c) Dynamic factors have been essentially neglected by many therapists when using hypnosis. They have viewed hypnosis as a state rather than as a dynamic or fluctuating alteration of consciousness. Yet clinically it has been observed that hypnotizability and the level of depth obtained are not fixed characteristics of

the patient. This observation is not inconsistent with nonhypnotic phenomena; for example, Reyher<sup>5</sup> has data which point to viewing repression as a fluctuating process.

It is not uncommon for many therapists to suddenly drop their psychodynamic orientation toward a patient, once he is hypnotized. To be sure, the hypnotized patient is in a *different* psychological state than when he is not hypnotized. However, this does not necessarily mean that a *different* conceptual framework has to be used to understand the current psychological functioning of the hypnotized patient.

In summary, then, it is maintained that therapists should feel comfortable about using the same psychodynamic principles to understand the behavior of hypnotized patients that they use to understand patients who are not hypnotized.

#### ILLUSTRATIVE CLINICAL SITUATIONS

Clinical situations will now be presented to illustrate both the explanatory and practical usefulness of the application of psychodynamic thinking to hypnotic behavior. The situations presented will be representative of hypnotic induction, behavior during hypnosis, depth of hypnosis, termination of hypnosis, and post-hypnotic behavior.

To begin the discussion of the induction process, the writer will report on his own failure to hypnotize a schizophrenic woman. This patient had been readily hypnotized a few days before by a psychiatrist colleague who was just beginning to learn hypnosis. There are many possible psychodynamic explanations for the patient's varying hypnotizability. One is that the woman was threatened by being in an unfamiliar situation; this explanation is consistent with the writer's clinical impression of her response to being hypnotized. One consideration in support of this threat-explanation is that the woman was the psychiatrist's patient, so that some sort of positive relationship existed with him, whereas the writer was seeing the patient for the first time. Another difference between the two hypnotic situations was that the psychiatrist hypnotized her in the ward setting, which was more familiar to the patient than the psychology office that the writer used; also, another psychologist, who was unfamiliar to the patient, was present in the office as an observer. Other explanations may be that there were differences in the personality structures of the

two operators, that there were changes in the patient's psychopathological status in the interval between the two hypnotic situations, and so on.

This last reason, the possibility of clinical changes in the patient, is probably related to the phenomenon of fluctuations in the hypnotizability of a patient from session to session, even with the same operator, an example of which is reported in a case in which hypnosis was used to diminish a Parkinsonian tremor.<sup>6</sup> In hypnotherapy, this fluctuation typically occurs when, as a result of working on a conflict, the patient begins to have certain feelings toward the therapist that he did not have before. At the next session, he may turn out to be un hypnotizable, presumably as a defense against having these feelings become more manifest; this is considered to be "resistance," similar to the concept of resistance as it is used in nonhypnotic psychotherapy.

An example of working through a patient's resistance to hypnosis is given by Conn.<sup>7</sup> By questioning a refractory subject, he found that she equated hypnosis with being like "a marionette" in the hands of the operator, which she resented because it reminded her of her pathogenic relationship with her mother. Conn responded by saying something like: "I am not pushing you around. Aren't you doing this to help yourself?" This response was sufficient to resolve her resistance, since she was hypnotizable immediately afterward.

Erickson reports a case<sup>8</sup> in which induction was achieved, not by resolving the patient's resistances, but rather by going along with them. The patient entered his office and began pacing the floor, explaining that this behavior was powered by his intense anxiety. Erickson first asked the patient if he would co-operate by continuing to pace the floor, to which the patient readily agreed. The patient then also agreed to allow the therapist to take a part in directing his pacing. Erickson proceeded to ask the patient to pace in exactly the same manner that he was actually pacing. "Gradually the tempo of the instructions was slowed and the wording changed to, 'Now turn to the right away from the chair in which you can sit; turn left toward the chair in which you can sit; walk away from the chair in which you can sit; walk toward the chair in which you can sit,' etc." After a while, Erickson had the patient sitting comfortably in the chair, and soon thereafter he was deeply hypnotized.

An interesting study by Kline<sup>9</sup> on antisocial behavior under hypnosis illustrates the importance of viewing hypnosis, not as a static "trance" or "state," but as a special kind of interpersonal relationship. The procedure was that four different experimenters individually requested the same subject to perform an antisocial act while under hypnosis. He did not perform it. However, on another occasion, each experimenter had the subject hallucinate an apparently different and socially acceptable act, but one which actually included the original antisocial act. Three out of the four experimenters' behavior resulted in a change in the significance of the antisocial act to the subject; he was then able to perform it. This suggests that the giving of suggestions to a hypnotized subject involves not only the utterance of words, but, in addition, has all the complexities, nuances, and process qualities characteristic of any interpersonal relationship.

The importance of nonverbal communication between subject and operator was also suggested by the Kline study. First, it will be noticed that one out of the four experimenters could not get the subject to perform the antisocial act, even after the other three succeeded. Later this same experimenter asked to be excluded from further participation in the experiment because she was getting upset, even though her anxiety was not overtly apparent to the other experimenters. Second, during another part of the experiment one of the experimenters could get the subject to perform the antisocial act, whereas the other three could not. The possibility that the therapist can influence the patient in subtle, nonverbal ways is the reason why Rosen<sup>10</sup> cautions therapists to be alert in preventing their patients from acting out the therapists' own fantasies when hypnotic acting-out techniques are being used. These nonverbal influences are also of interest to nonhypnotic psychotherapists, since they are currently under investigation in a major psychotherapy research project.<sup>11</sup>

The results of Kline's study<sup>9</sup> imply that the hypnotic interpersonal relationship between therapist and patient is much closer than during the waking state, an observation which Lindner<sup>12</sup> explicitly mentions. Those readers who have had some experience with trance induction will probably recall how rapidly they gained an understanding of, or feeling for, the patient's personality during the induction process. Also, the converse is true in that subjects whom the writer has questioned about experiences in being

hypnotized usually mention a heightened sensitivity to the personality of the operator. One explanation for this intensification of the relationship has utilized the concept that induction is based on stimulus deprivation, or stimulus stereotypy.<sup>13</sup> In either case, the subject pays less attention to the environment and more to the operator. Likewise, the operator is not distracted by the environment, since he is focusing his attention on the patient. Therefore, the operator is, in the distraction sense of hypnosis, "partially hypnotized," and consequently in a closer relationship with the patient. This suggests that, as equal attention begins to be focused on the operator's contribution to the relationship, a greater understanding of some of the paradoxes of hypnosis will evolve. In this connection, it is interesting to note that, in an analogous manner, an increasing emphasis is being placed on how the therapist's needs and personality affect the course and outcome of psychotherapy.<sup>14</sup>

Ehrenreich<sup>15</sup> has reported a case which throws some light on the phenomenon of depth of hypnosis. The subject involved exhibited deep trance hypnotic phenomena of various kinds but could not carry out a specific suggestion usually considered characteristic of a light trance, hand-clasping. Through hypnoanalytic procedures over several sessions, it was possible to discover repressed childhood experiences which were related to the apparent inability to carry out the hand-clasping suggestion. As a result of the recovery of these memories, the subject suddenly responded to the suggestion and continued to do so from then on. The conclusion that Ehrenreich drew from this case was that the conventional criteria for indicating the depth of hypnosis may prove to be less than adequate, because subjects appear to be strongly influenced by unconscious factors in their responses to the various depth tests. Erickson's experiences<sup>16</sup> are consistent with this point of view.

Related to the problem of the reliability of tests of hypnotic depth, Brenman et al.<sup>17</sup> report that it is not uncommon for spontaneous fluctuations in the depth of hypnosis to occur within a single session. Similarly, Schneck<sup>18</sup> reports that some patients experience a feeling of depth reduction after being given the signal for termination, but that their hypnotic level then becomes deeper than it was originally, rather than terminating. He offers three reasons for this depth reversal phenomenon: (a) The patient wishes to continue receiving whatever psychological gratification

he has been getting during hypnosis. (b) The patient wants more time in hypnosis so that he can finish working on the particular problem that he was working on before the signal for termination was given. (c) Since the hour is over, the patient may feel less threatened and is thus able to relax some of his defenses against going into deeper hypnosis.

Termination of hypnosis is another situation where an understanding of the psychodynamics involved is important. The typical problem is one in which a subject does not become dehypnotized on the operator's signal.<sup>19</sup> Often neophytes become seriously concerned by this situation; some wonder if the patient will ever wake up. It has been suggested that this problem be handled in the same manner as one handles a patient who refuses to leave the office after a session of nonhypnotic psychotherapy.<sup>10</sup> That is, difficulty in dehypnotization may be viewed as a resistance to be worked through. Rosen gives an example of a rigid, obsessive patient who did not dehypnotize on signal during a treatment session. This was because he had timed the 50-minute sessions and found that he had been "cheated" out of 4 minutes and 28 seconds over the course of his 12 sessions. Therefore, the patient had decided to cheat the therapist out of twice that amount of time. Rosen "... stated that the factors back of this reaction of his were significant and therefore warranted detailed discussion next time. Nevertheless, even though the session had ended, if he wished to remain, he could. This would necessarily be on the next patient's time and with the next patient's permission, and he would therefore be billed for this at the rate of \$25.00 for each fifty minutes, the fee paid by the patient whose time he was now using. While saying this, the therapist again gave the signal for dehypnosis. Our patient was immediately dehypnotized, rushed to the door and slammed it angrily as he fled from the building."<sup>10</sup>, p. 228

Post-hypnotic compliance was investigated by Rosenberg and Gardner<sup>20</sup> by studying the case records and hypnotic behavior of four subjects. They found that post-hypnotic compliance was facilitated by the subject's being able to interpret the content of the post-hypnotic suggestion in a manner consistent with the mechanisms and affective reactions that, for him, also characterized his entering and remaining in the hypnotic relationship. They also found that compliance was facilitated if it permitted subjects to

express a drive that they were previously in conflict about expressing.

#### SUMMARY

The thesis of this paper was that psychodynamic variables affect both the induction of hypnosis and behavior after induction. It was, therefore, maintained that psychotherapists should feel comfortable about using the same psychodynamic principles to understand their hypnotized patients that they use to understand patients who are not hypnotized. Clinical situations involving hypnotic induction, behavior during hypnosis, depth of hypnosis, termination of hypnosis, and post-hypnotic behavior, were then presented to illustrate both the explanatory and practical usefulness of the application of psychodynamic thinking to hypnotic behavior.

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## DYNAMICS IN HOSPITAL RECOVERY OF PSYCHOTICS

BY CHARLES WATKINS, M.D.

Much of the increased interest in psychiatry in the last two decades has centered around advances in treatment. Two types of therapies have gained the attention of the profession and the laity alike, to the disadvantage of some of the less spectacular aspects of the therapeutic armamentarium. Individual psychotherapy, particularly of the intensive type, captures the imagination of the layman, and serves well the investigative interest and the narcissistic needs of the therapist. The drastic therapies, EST, insulin and now the tranquilizers, have appealed to the mass production inclinations of our culture, and offer a method of handling large numbers of patients, as well as of satisfying in a culturally acceptable manner possible hostile sadistic impulses of the doctor. Because the objectives of the two types of therapy appear on the surface to be so different, there has been a tendency for therapists to fall into camps; not hostile, perhaps, but to say the least, certainly defensive of their philosophies and results. This has resulted, to a degree, in an increased preoccupation with refinements of their particular techniques to the neglect of other methods of therapy, and of a possibly very advantageous synthesis of methodologies.

Such a tendency to restrict the concept of therapy has worked to the disservice of psychiatry, and should be combated.

There is universal agreement that better psychiatric care is needed. Realists agree that the Utopian concept of intensive therapy for all patients is impossible of realization; both because of economic factors and the lack of capacities of some patients to utilize such therapy. As yet, the ultimate weapon in the realm of psychopharmacology also escapes our grasp.

What then is available? An entirely new method of treatment, no matter how desirable, cannot be the only hope. It is too problematical. There remains the possibility of a better utilization of techniques and/or an adaptation of present insights to new techniques.

The effect of hospitalization and the hospital environment *per se* has received relatively little attention. Notable exceptions are the work of the Menninger group<sup>1</sup> on milieu therapy, that of Stanton and Schwartz<sup>2</sup> on the mental hospital and that of Jones<sup>3</sup>

on the therapeutic community. This discussion will concern itself primarily with that form of relationship, outside the patient-therapist role, and will consider the relationship to the everyday environment, that is, to the hospital as a therapeutic agent, with remarks on the effecting dynamisms and how they can better be studied and utilized.

The utilization of this relationship as a therapeutic agent is not a new concept, nor a rare practice. Many psychiatrists have advocated such an approach to the problem of the care of psychiatric patients. The technique has, however, too often been considered merely an expedient to be resorted to when nothing better was available. The techniques of handling such a therapeutic tool have not been systematically studied and developed. This lack of positive attitude toward the patient-environment relationship has meant that it has not gained the status of an independent therapy, valid and useful in its own right, but rather is considered a makeshift, utilized because of the unavailability of other techniques.

It seems necessary to emphasize that it is not suggested here that the relationship of the patient to the hospital will accomplish a task as great as that which is possible by working through the transference in the doctor-patient relationship. Within the limits of its effectiveness, however, the hospital-patient relationship is of definite therapeutic value; its effect appears to be based on principles similar to those of individual psychotherapy, and a systematic utilization of insights into such principles will make possible much more therapeutic benefit in hospitalization.

If this thesis is valid, there are, in the psychiatric hospital, therapeutic forces that are effective and available for immediate exploitation. A not inconsiderable benefit of such agencies would be their effectiveness, if publicized, in relieving the dread and feeling of hopelessness so often associated with psychiatric hospitalization.

Several questions pertinent to the problem may be raised:

1. Are there factors that fairly consistently influence patients toward recovery?
2. What are the factors that make such benefit possible?
3. Are these factors subject to experimental validation?
4. Can such factors be utilized to any extent greater than is now being done?

5. Are there factors inherently present in the hospital situation that may be utilized to greater advantage than they now are?

The psychoanalytic technique has given us material indicating the importance of the interpersonal relationship in personality formation. Analysis has worked particularly on the genetic-dynamic factors in the causation of illness, but has made considerably less progress in applying the insights so gained to the understanding of the process that takes place during "spontaneous" recovery. Even less progress has been made in adapting this knowledge to a clinical methodology, utilizing the general environment. The transference situation in the analytic process has, of course, been well investigated. Transference itself has often been the factor considered to be therapeutic, without enough attention being given to the dynamisms at work which made utilization of transference possible. The establishment of the experimental situation that produces and utilizes the transference phenomenon offers an opportunity to gather material and develop theories of relationship and interaction that can be applied empirically to dynamisms operative in relationship in general. Within such a theoretical framework, it would become possible to establish a frame of reference for a scientific understanding and utilization of the dynamisms at work in the patient-environment relationship, similar to the understanding and utilization now well established for the patient-doctor relationship.

#### HISTORICAL

In a purely nonmedical framework, the value of group relationship has been known for centuries. The military have, since time immemorial, utilized the force of *esprit de corps* to stimulate the healthy, productive integration of the individual into the group. Political parties and churches have been aware of the influence upon the individual of such group forces. Guilds, and now labor unions, have clearly demonstrated the effectiveness of such a participation. The team loyalty of the typical undergraduate or of the old-time Brooklyn Dodger fan indicates again the usefulness, not only to the individual, but also to the larger unit, of such relationship.

This insight has not been lost entirely on medicine, and there have been efforts to understand and use such forces.

Freud,<sup>4</sup> in his monograph on group psychology, offered a theoretical base line. Moreno,<sup>5</sup> in his work on psychodrama, and more particularly in his sociometric studies, has attempted, by a scientific methodology, to study and utilize the operating forces. Experimentalists such as Masserman,<sup>6</sup> with his work on experimental neurosis, particularly the curative effect of associating the neurotic animal with a healthy one, have opened wide the gate to laboratory experimentation. Among others who have contributed here are Lidell and his co-workers at Cornell<sup>7</sup> and W. Horsley Gantt at Johns Hopkins.<sup>8</sup>

Bruno Bettelheim,<sup>9</sup> in *Love Is Not Enough*, describes the working of the Chicago Orthogenic School and demonstrates clearly the value of group relationship as a therapeutic agent in work with children. Charcot<sup>10</sup> had touched upon this decades ago.

In the experimental situation designed to develop to the fullest the transference relationship as a therapeutic tool, several basic attitudes and needs served by the relationship of the doctor and the patient become evident. The writer believes it can be categorically stated that these dynamisms form the framework upon which the transference phenomenon is able to accomplish its therapeutic benefit.

The patient finds in his relationship with the doctor several clearly defined and specific environmental dynamisms that make possible certain changes in his attitude, which he is able to exploit in his work toward recovery.

1. Initially, it is necessary to establish with the patient a mutually acceptable and definitely outlined system of efforts and rewards. It is by this agreement that the patient becomes free to accept the help of the physician. He is not threatened by the possibility of later, unrestricted and possibly disproportionate, demands being made upon him. The doctor must establish with the patient that he, the doctor, is being mutually rewarded, in and by the therapeutic process or its monetary compensation, before the patient is free to accept such benefit as may result to him from the therapeutic work.

2. Second, the patient finds in the doctor someone with whom he can communicate. Communication of feeling and thought is a problem with all psychiatric patients. Not only does a patient often feel completely frustrated in his ability to understand his symptomatology and its meanings; but, in attempting to discuss

the problem with outsiders, even physicians, the problem of communicating to the other person his own feelings and attitudes appears insurmountable. It is necessary to indicate to the patient one's awareness that all is not right; also, for definitive work, it is necessary to communicate to the patient, to the extent that he is aware of at least an empathic understanding of the problem.

3. In the establishment of the transference situation, it is necessary to indicate to the patient that, on the level of personal individuality, the patient is equal to the doctor, the inequality of the two in the therapeutic situation being purely that of professional skill. Any inequalities of the doctor and patient outside the treatment situation are accepted as not operating during the treatment session. It is only with this degree of equality that a patient's free expression of ideas which possibly conflict with those of the therapist can take place. The patient is assured that he, as an individual, has the right to express himself even to the point of error; but he is assured that, in the particular situation, the technical skill of the therapist will work to prevent the patient's experimentation becoming injurious to the patient; he is to understand, on the other hand, this experimentation can be turned to advantage by guidance.

4. The psychotherapeutic relationship offers stability of task-demands by the environment. Psychotherapy is a work process with, if it is to be effective, clearly defined demands as to procedure, activities and expected accomplishments. The therapist, in his evaluation of the situation, should decide what the limits of the patient's capabilities are at the time, and then indicate what procedural activities are expected. The patient then learns that he has a specific task in the co-operative procedure and that he will not be required at the whim of the therapist to develop new methodologies and techniques. Such stability serves well in increasing the patient's work, his capabilities and his willingness to take on new tasks.

These components of the doctor-patient relationship are effective in the therapeutic situation of analytic-type therapy, because they help establish the picture of a stable, understanding, nonexploiting milieu, in which the patient is able to test out his impulses in a protected and protecting environment, and to develop new attitudes and techniques more effective in relation to day-by-day living. It is thus that the transference becomes exploitable.

In the nonanalytic psychotherapeutic situation, the therapist enters more actively into current events, corrects misconceptions on intellectual levels, reassures, uses suggestion and other therapeutic tools. The situation is not so nearly an experimentally controlled one, but the factors of the relationship of the two people should be as clearly defined.

The questions arise then: If such dynamisms are the basis of transference work and other forms of individual psychotherapy, is it not possible that these same tools could be utilized as therapeutic agents in more general situations; and are not these relationships available for use therapeutically and investigatively in the psychiatric hospital?

What does the hospital offer to the patient, and what is the patient's relationship to the new environment?

Ideally, the psychiatric hospital is an asylum, using Webster's definition, a place of refuge, a sanctuary. The word has fallen into ill repute when used in connection with psychiatric hospitals, but even now the concept of sanctuary is not without merit. The patient should receive sanctuary, not only from the unreasonable demands of the environment, but also from the consequences of possible inappropriate activity. Here, then, are two of the factors that were operative in the situation experimentally produced to utilize the transference phenomenon: 1. Unreasonable demands are not placed upon the patient. 2. The patient is made aware that, in the hospital setting, as in the analytic situation, the environment, the hospital personnel or analyst, will permit experimentation of behavior only to the degree that is not irreparably harmful to the patient, or dangerous to the environment. Then free association—or in the hospital situation, working through or acting out—becomes possible.

Examples of the value of such relationship are numerous. One may mention a patient who commented, toward the end of his illness, that hospitalization was the turning point toward recovery, because he felt it no longer necessary to keep up a front. Another instance is that of a catatonic patient, whose refusal to eat was handled simply and effectively, but in such a manner that she was made aware that, in spite of her feelings, she would not be permitted to do herself bodily harm.

Such instances, acted out by the hospital psychotic and the environment, are actually of the same order of things as the

assurance that the neurotic analysand must receive before primitive emotions can be released. This is revealed by the comment made by a patient late in therapy that the release of much feeling was held up because the physician had not shown the patient that he was aware of the degree of rage the patient felt, and thus had not assured the patient that controls would be applied if needed.

The psychiatric hospital offers an opportunity to communicate with others. The new patient learns, relatively early in his hospital stay, that there are people present who speak his language.

The group discussion of symptomatology and problems that goes on unceasingly in the psychiatric ward serves many of the functions attributed to more formally organized psychotherapeutic groups, and such ward groups are based upon insights gained from, and procedures similar to, the individual sessions.

The nonformal ward discussions serve several purposes. 1. The patient is reassured that problems such as his may be discussed. 2. The discussion of personal problems by others helps to indicate to him the universality of emotional conflict. 3. He frequently becomes more able to verbalize his own conflicts. 4. The expression of attitudes of understanding and acceptance by others makes possible discussions that bring some abreactive value. 5. The patient is strengthened by the development within himself of an introjected group ego—he is no longer isolated. 6. The patient occasionally gets spontaneous deep insights. 7. He learns methods to handle his relationships with the group.

The psychiatric patient in the hospital is in a situation probably unique in his existence, in that he is in a group of his peers. True, members of the hospital personnel are usually considered to be somewhat different from the patients. The new patient, however, can fairly easily approach other patients and adjust to them as an equal. It may be an abnormal situation, but none the less, the patient is functioning as an equal in the environment. And, ideally, he should be able to communicate with the hospital personnel on a basis of equality in the professional situation, influenced only by the greater technical skill of the therapist.

Another point of reassurance about personal individuality, which results from hospitalization, is equality of treatment by authority figures. The psychotic patient, particularly the schizophrenic, has long been aware that the treatment he has received from parents, and parent figures, has not been similar to the treatment accorded

to many of his acquaintances. The psychotic patient on the hospital ward is, in the usual case, one of a group of patients. He is not singled out for special attention, or restriction, and, although he is frequently much restricted in activities by the needs of his illness, he is able to accept restriction from an authority like a doctor or nurse much more readily than is possible in more usual settings. Going outside the field of medical conditions, the armed forces provide a perfect example of the ability of the individual to accept frustration and indignity—if in a military setting—that would be intolerable otherwise. This ability to accept restriction in an appropriate setting is demonstrated by the behavior of the patient, brought to the hospital in manacles by the police because of violent behavior, who quiets spontaneously soon after entrance into a psychiatric ward.

In the hospital situation, as in the psychotherapeutic interview, it is possible to work with the patient as an equal except in the matter of technical skill and job responsibility. Such acceptance of the patient effectively serves to reinforce the functioning ego-strength of the individual, and tends, by the fact of its emphasis, to minimize the psychotic symptomatology. That is, it functions as do the attempts of the psychotherapist to re-repress the unconscious.

Stability of behaviorial expectancy in the hospital setting is immediately established by the integration of the patient in the hospital routine. There should be a fairly fixed routine by which the basic biological needs of the patient are met; then the assessment of the individual patient's ego-function will determine what therapeutic routines need be established. With the establishment of the day-by-day regimen, the patient has begun to work toward recovery, just as does the patient who becomes acquainted with, and learns to function within, the rules of procedure in psychotherapy. The demands of the environment concerning this work-program, if realistic, will be within the patient's proximate capabilities, and can be steadily worked toward. The patient will be able to associate demand, activity, and reward, in such close connection and with such a degree of certainty, that the associational pattern will not be interrupted. This means that the patient has found in the hospital setting a predictable environment that makes work toward recovery justifiable. The environment thus relieves anxiety by the establishment of two clearly defined facts:

1. The demands made by the environment, insofar as activities are expected of the patient, are consistent; and, once learned, can be expected to remain stable, changing only as the patient's ability changes.

2. The demands of the environment are predicated upon the needs of the patient, and not upon the needs of the environment.

These two factors indicate to the patient, without verbal communication, that the activity of the patient-hospital constellation is oriented toward working for the patient. This insight is reinforced by the establishment of the fact that the personnel of the environment are being rewarded for their work for the patient and should, therefore, not be expected to make demands later that were not previously agreed upon.

#### SUMMARY

Some dynamisms that appear to be part of the effecting agency of individual psychotherapy are presented; these can be noted in the varied techniques of psychotherapy; they appear to be subject to validation by an acceptable scientific methodology.

Some of the dynamisms of hospitalization and the hospital environment appear to be of a similar order to the dynamisms noted in individual psychotherapy. These factors have been utilized and are being utilized empirically throughout psychiatry at this time, but too little attempt has been made to systematize the techniques so that they can be employed to maximum efficiency. The development of a systematic methodology, based upon facts experimentally proved in individual therapy and animal experimentation, and then adapted to a broader methodology, offers a method by which a great body of otherwise inaccessible patients could receive active, dynamic psychotherapeutic benefits.

#### CONCLUSION

1. The dynamisms responsible for psychotherapeutic effects can be demonstrated in experimental situations.

2. These same factors can then be seen to be acting in other situations; specifically, in this discussion, in the hospital environment.

3. The insight offered by dynamic psychiatry makes possible a greater utilization of the resources available in the relationships of the patient to the hospital environment.

4. A relationship to person or environment is a valid and utilizable psychotherapeutic agent.

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## EVENTS AND CONSCIOUS IDEATION LEADING TO SUICIDAL BEHAVIOR IN ADOLESCENCE\*

BY HENRY I. SCHNEER, M.D., PAUL KAY, M.D., AND  
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Eighty-four adolescents (aged 12 to 16) who were admitted to Kings County Hospital, Brooklyn, during 1956 and 1957 for suicidal behavior comprise the material of this study. "Suicidal behavior," as used in this paper, includes threats and attempts at suicide. The category of threats include such displays of feeling and gesture as to provoke either the family or an authority into hospitalizing the patient. While some authors<sup>1</sup> have distinguished attempted from completed suicide as separate entities, none has made a similar distinction between threats and attempts. One of the findings in the present study indicates that "threats" and "attempts" represent aspects of a continuum of suicidal behavior which could culminate in death. In no instance, has the suicidal behavior of the writers' adolescents resulted in death, although there were many instances in which death could easily have been the outcome.

A link between "threats" and "attempts" lies in the frequent shifting from threats to attempts and vice versa in the same patient in a period that may range from minutes to years. This occurred in at least a third of these patients. For example, one girl drank rubbing alcohol and green ink, tied rope around her neck and threatened to jump out of the window, in rapid succession. Another patient threatened suicide for two years before making attempts. Still another made two attempts in two different years before hospital admission, and was admitted for a threat. Furthermore, there were no essential differences in the manifest events and conscious ideation leading to the suicidal behavior as between the threat and attempt groups.

The present material is organized to describe and elucidate the meaning of the events and conscious ideation leading to the suicidal behavior, and the behavior itself, which was rarely warranted by the manifest circumstances.

\*This paper presents one aspect of a larger study on suicidal behavior among adolescents, conducted in Kings County Hospital, Brooklyn, N. Y. by members of the department of psychiatry, State University of New York, College of Medicine (Downstate).

The manifest events consisted most commonly of: *separation* (from parents and other significant persons or objects), *disclosure of forbidden activity* (e.g., drinking beer in school), *defiance* (of parents or other authorities), *restriction* (by parents), and *criticism* (e.g., for obesity by a friend). Less frequently occurring circumstances were *discovery of adoption* of the patient, or discovery that a parent was not the biological parent, *exclusion* or *expulsion* or *banishment* (e.g., from home or school to an institution), and *corporal attack*. These events occurred invariably in connection with conflicts, chiefly with the parents, but also with other authority figures.

The conscious ideation consisted of thoughts about punishment, being separated from parents, criticism, ridicule, deprivation, being unloved and unwanted by parents, being beaten by parents, hurting and killing parents and siblings, jealousy of siblings, rape, defective sexual identity, coercive and dramatized bids for attention, and getting rid of auditory hallucinations.

As would be expected, there is more ideational material in the threat group than in the attempt group, where action prevails. There are, however, as stated previously, no specific major differences in the events and ideation of the threat and attempt groups.

In regard to sex, however, differences appeared in the entire patient group (84). The girls revealed a pattern of preoccupation with being raped, although at the same time they were actively involved socially and heterosexually—to the point of promiscuity in several instances. The boys, on the other hand, showed a concern over masculine identity and genital damage and were combative with their parents, with the mother in particular.

A further significant finding in regard to the whole group was the factor of parental loss or separation. The biological father had usually lost more or less permanent contact with the family. The biological mother had usually retained contact, although it might be marked by gross neglect, or affected by intermittent illness in herself or the patient, or employment away from the home. The mother was often punitive or detached.

The events and ideation just reported are not unusual in adolescence, and are not specific for suicidal behavior in adolescence. They led to suicidal behavior in the adolescents studied here, because they represented an overwhelming crisis in sexual develop-

ment and control of aggressive urges, as predetermined by reactions to previous traumatic experiences.

The writers' method in elucidating the latent meaning of the suicidal behavior was to look upon the events and ideation leading up to them as if they were the manifest content of a dream\* and, in lieu of free associations as to a dream, the patients' previous life experiences were used.

#### CASE EXAMPLES

The following are examples from the case material.

##### *Charlotte*

Charlotte, 15 years old, brought beer to school on the day before Christmas vacation to join a party of students. She drank an unknown quantity, was found out and threatened with expulsion. In her worry over hurting her father and spoiling her chances to become a policewoman as she wanted to be, she brought a loaded gun to school and threatened to shoot herself. She wanted the principal to change his mind about the expulsion. Later she indicated that she had also brought the gun in an effort to be a "big shot." The gun belonged to her mother who kept it as protection against what she regarded as her dangerous neighborhood.

Charlotte's life chart revealed that her birth was unplanned. Her mother had wanted a boy, since she was "not the type to raise girls." The patient and her siblings were "raised according to the book." When she was five, a fear of insects started and has persisted. She became "tomboyish." She also became quiet and withdrawn. She remained lonely and apparently never became, or felt, part of the family. Her mother took her to school until her eighth year, but she was close only to her father. The father, however, was often away from home. When he was present, he and the girl often went hunting and fishing together.

At puberty Charlotte would wait for her women teachers after school, photograph them and frequently telephone them. She would become very hostile to teachers who left her with unrequited crushes. When she was close to 13 years old, she claimed she had

\*A precedent for this method may be found in psychoanalytic pathographies. An analytic approach, as to a dream, is effective as a means of understanding what would otherwise be an incomprehensible, isolated, enactment of unconscious conflicts. The writers know of no psychoanalyzed suicidal adolescent patient to serve as an example. Literary characterizations of suicidal adolescents are found in various novels, plays and myths.

been "attacked" by a boy. The mother went to the school, the principal was provoked to hostility, and then the mother turned on the girl. Most of the patient's social relatedness centered around an older, retarded brother, whom she protected and whose friends she led. She was not close to her sisters. However, she took care of her married sister's baby son the summer of her fifteenth year. Her menarche at 13 was the occasion for her mother giving her reading matter.

Shortly before the beer party and her suicidal behavior, Charlotte developed an infatuation for a boy who left for service in the navy. Her joining the beer party at school appeared to express a wish to join with her peer group in defiance of authority and in a ceremonious conviviality before Christmas. Manifestly, this wish and its fulfillment would appear to be an adolescent prank of rebelliousness at holiday time.

What forces were at work to make this adolescent, prankish effort to gain apparent socialization become a step in the direction of suicidal behavior?

If one takes the available data of her life events in a sequence, it is to be noted that, preceding the beer party, the first boy in whom she had shown interest had left for the navy. A few months before that event, she had spent the summer taking excellent care of her sister's infant son. At about the time of puberty she had complained to her mother that a boy had tried to attack her. These occurrences, for a girl who had always been a tomboy, indicated the emergence of heterosexual inclination—revolutionary in her psychosexual development. A crisis for identity as a female was precipitated by the "boyfriend's" departure. This crisis was also suffused with hostility, the origin of which was in the repeated absences of her father throughout her childhood. She was considered to be her father's pet. She appeared withdrawn to the family except when she was with the father, and, to a lesser extent, when with her retarded brother.

One may now speak of a three-fold aim concealed in the rebellious adolescent beer party. First, there was a desperate wish to confirm herself in identity as a female through identification with her adolescent boy and girl peers. Previously in her life her cohesive group experience consisted of her retarded brother and his friends, emphasizing her masculine identity. The holiday beer party, in a symbolical sense, may be conceived to have been a rite

of initiation. Second, there was the wish to avenge herself for being turned down as a girl by the leave-taking of the boyfriend, and, before that, by a father who appeared to have accepted her only as a boy. Third, a wish prevailed to sever the tie with the mother which was based upon the idea of being loved as a tomboy, not a girl. That the beer party should have led to disclosure of forbidden activity and the threat of expulsion by the authorities is understandably determined—if viewed as the operation of guilt, arising out of defiance and vengeance, which however, demands punishment. To dare to be a girl and a defiant one is punishable. Expulsion meant consciously, to her, hurting her father and losing her chance to be a policewoman. This is paradoxical because her rebellious behavior at school had already disturbed her parents.

Further, the paradoxical behavior, in endangering her strong conscious wish to find an identity as a policewoman, can be understandable from the point given of avoiding more powerful inner dangers. In not materializing her identity as a policewoman, she could avoid: (1) The personification of conscience in the form of her sublimated mother image, prohibiting the Oedipal wish (her father appeared to prefer the bisexual image); and (2) the identification with her mother as the hated, feared image—a cold, frustrating, mechanical person.

The suicidal behavior itself may now be considered: taking the gun and threatening to shoot herself.

As the girl with the gun, the tomboy, she would appear to be regressively attempting to repair the damage brought on by her miscarried attempt to gain femininity. The damage consisted of loss of love and threat of expulsion from school. But it was mother's gun. She was now like her mother, the phallic woman. But this identity was no longer acceptable. Thus her wish to be a "big shot" with the gun and her threat to shoot herself went beyond the idea of destroying the hated introject (mother) to the stage of infantile omnipotence and fusion with the mother as the final solution.

In this way she would lose her identity as an individual and would no longer need to cope with the oppressive, guilt-laden problems of sexual identification and aggression. It may be recalled that the patient's passion was to photograph or "shoot pictures" of the women teachers for whom she developed "crushes." Here,

the libidinal and aggressive impulses toward the introjected object, the mother, can be recognized—displaced onto the teachers. When one considers the omnipotence factor and fusion with the mother, one may note Lewin's conclusion that psychologically, suicide may represent a fusion of ego and super-ego,<sup>2</sup> or a return to the mother. Lewin suggests also that suicide need not necessarily be depressive, but can be manic just as well—a consideration where the moodiness of adolescents is concerned.

### *Carol*

In comparison with Charlotte, promiscuity, anti-social behavior, overt hostility toward her parents, and feelings of deprivation are outstanding in Carol's history. The homosexual conflict is not so apparent.

Suicide was attempted when Carol was 15, when she drank her mother's "nerve medicine" in school. The manifest circumstance was notification to the mother that Carol had started to truant again after having been recently placed on probation for truancy. On conscious, and perhaps preconscious, levels, the suicide attempt was a self-punishing, coercive bid to dissuade the school (and parental) authorities from punishing her by banishment for the renewed truancy.

In a review of the patient's history it was found that the truancy had been preceded, a few weeks before, by her locking herself in her room and refusing to go to school. The police had to be called to get her out. She had screamed then that her mother did not want her, that mother had not "understood" her and felt as "cold as a stone." The truancy may now be viewed as the expression of an angry wish to be wanted, loved and physically near a mother who really did not want her. This fact is understood by the mother's panic and guilt during her out-of-wedlock pregnancy with the patient. The suicidal behavior may be recognized as a last, desperate wish to get her mother by the magic of something of mother's i.e., her "nerve medicine." Other indications of retrieving a fusion with the mother long antedated the suicide attempt.

In her puberty and childhood, Carol would wear her mother's clothes and steal her money. Her continuous defiance of the mother, culminating in the suicide attempt, represented an accumulation of aggressive energy discharged inwardly against the incorporated object of her mother. Another source of her death wishes came from the Oedipal hostility engendered in her argumentative

relationship with her father. She threatened to kill her father when he stopped her allowance as a punishment for lying, stealing, truancy and alleged promiscuity. The psychosexual, aggressive conflict with her father was elicited from two stories she had told the girls in school about a year before the suicide attempt. One was that her father was her stepfather and the other that she had been raped. She left a written note, which her teacher "found," about having been raped. During the same period, she was upset because her boyfriend had refused to "go steady" with her. She could not be a woman loved by a man, either as daughter or girlfriend. Then she turned back desperately to the first frustrating love object (or need-gratifying object), her mother, as she did in locking herself in the house. But again she was rejected by her mother. The rage consequent to this series of rejections was turned inward upon the fused self-and-mother.

### *Michael*

The third case example is of a 12-and-a-half-year-old boy.

The angry and desperate wish to hold on to a rejecting and, at times, abandoning mother plays a prominent role in the suicidal behavior of boys as well as girls.

Michael swallowed a heavy dose of sleeping tablets and was hospitalized in a state of coma. Manifestly, this was in reaction to his mother's criticism of him for not meeting his new, and third, stepfather. The mother had remarried about four months previously and, during that time, the boy had been depressed by suicidal ideation. He also had feared his penis was too small; that he would not be a man; that he would be attacked sexually by boys. By viewing these manifestations in the light of the desertion of his biological father when he was 20 months old, his mother's marriages, her promiscuity, and her aversion to raising children—all of which led to arrangements for his rearing first by her mother and then in various foster homes (from which he was always running away)—Michael's craving for his mother was constantly stimulated and finally repressed in the course of rankling for revenge.

A recent accusation that his mother wanted to give him away, and his tantrums and nail-biting since early childhood not only indicated a chronically growing rage against his mother but the inward direction it took. When he was asked to meet his third

stepfather, another blow to his embryonic masculine identity was delivered. If, from his sexual fears, one recognizes envy of the female, since it is she who gets the craved attention, then, in killing himself, he accomplishes in the same stroke the destruction of himself as the hated mother image and gains possession of the mother in fantasied, eternal fusion with her. The wish to be feminine and to be attended, but to be attacked like his mother, created the intolerable ordeal of meeting his stepfather.

#### DISCUSSION

Psychoanalytically dynamic factors found in these adolescent cases—such as the turning of aggression against the self, killing the internalized hated object, and joining the lost object—may be found also in studies of suicide among all age groups. The period of adolescence, however, shows a remarkable rise in suicidal behavior from the period of childhood. It is the writers' impression that the crisis of identity in the sense of fulfilled identification as male or as female, as it is found in adolescence, is particularly significant for the increase of suicidal behavior among adolescents as compared with children. For the subject of this study, the genital awareness and the continuing confrontation with the Oedipal struggle at adolescence led to a revival of unbearable memories of old frustrations; and through loss or rejection at the hands of the parents, interference with realization of the self as male or female.

Suicidal behavior, furthermore, provided the primitive, magical omnipotent infantile solution for the enraged, guilt-laden but desperate wish for fusion with the mother. The biological father, while usually the object actually lost to the child or adolescent in one way or another, had a secondary role and one based on frustration caused by the mother, who, however, physically was more or less present throughout the child's life. Stengel et al.<sup>3</sup> saw an "appeal function" in attempted suicide. If the family recognized the appeal for attention, repetition of attempts or threats would not occur.

The present study indicates that the "appeal" of the suicidal behavior among adolescents, whether suicide is attempted or threatened, represents a specific plea for help in dealing with the problem of sexual identification and its associated libidinal and hostile impulses aimed at the parents. The manifest events and conscious

ideation in the suicidal behavior among adolescents cannot be taken at face value, if the appeal for help in dealing with the identity crisis is to achieve response.

The choice of an approach as in the analysis of a dream in understanding suicidal behavior among adolescents would seem especially suitable, because even the everyday waking life of adolescents is itself characteristically punctuated by eruptions of the primary process in feeling, thinking and action.

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## SOME OBSERVATIONS ON THE EMOTIONAL POSITION OF THE GROUP PSYCHOTHERAPIST

BY W. DONALD ROSS, M.D., AND ARIK BRISSSENDEN, M.D.

There have been only a few papers published on counter-transference in group psychotherapy in recent years. Three articles on this topic, by Mullan,<sup>1</sup> Kotkov,<sup>2</sup> and Stroh,<sup>3</sup> have been found in group psychotherapy journals since 1953, whereas at least 14 papers on the reactions of the analyst have appeared in psychoanalytic journals over the same period.

Altogether, there are about 55 papers on counter-transference in the psychoanalytic literature and at least 16 in the group psychotherapy literature. Space will not be taken here to review this material. It is interesting to note, however, that three of the psychoanalysts who contributed to the increased attention which was given about 20 years ago and again about 10 years ago to this aspect of the psychoanalytic process are also group psychotherapists (Balint,<sup>4,5</sup> Berman,<sup>6</sup> and Grotjahn<sup>7</sup>). An excellent historical summary of the psychoanalytic papers up to 1954 has been provided by Orr,<sup>8</sup> and the most comprehensive account pertaining to group psychotherapy is contained in a Symposium on Counter-transference, published in the *International Journal of Group Psychotherapy* in 1953,<sup>9</sup> which includes papers by Flescher,<sup>10</sup> Grotjahn,<sup>11</sup> Hadden,<sup>12</sup> Loeser and Bry,<sup>13</sup> Slavson,<sup>14</sup> and several others.

The title of the present paper is in terms of "the emotional position," following the lead of Gitelson<sup>15</sup> and Loeser and Bry,<sup>13</sup> because of the controversies about the exact definition of the term "counter-transference." Discussion of "emotional position" allows one to deal with various reactions of the group psychotherapist, without concern as to whether these come within a *strict* definition of counter-transference, as limited to unconscious reactions of the therapist in response to the transference reactions of the patient.

The observations which follow have been influenced by many of these previous contributions. They have been made in the course of supervision of group psychotherapists in training, by means of group conferences (Ross, Block and Silver<sup>16</sup>), wherein the various staff members who are present contribute to greater perspective on the emotional involvement of the therapist with the others in the groups.

These observations will be discussed under four headings: 1. Reactions derived from the nature of group psychotherapy as contrasted to individual psychotherapy. 2. Reactions inherent in selecting a particular type of group. 3. Reactions arising in relation to individuals within the group. 4. Reactions in relation to one's professional subculture.

#### 1. REACTIONS DERIVED FROM THE NATURE OF GROUP PSYCHOTHERAPY

These reactions can be highlighted by reference to a phrase of Grotjahn's,<sup>1</sup> that group psychotherapy is like "working in front of a gallery of mirrors." This has its disadvantages and its advantages.

Some of those who prefer doing group psychotherapy rather than individual psychotherapy are individuals who have anxiety about the close one-to-one relationship of individual psychotherapy and who may tend, instead, to "hire a hall," to deal with people *en masse*. The group may be used for narcissistic exhibitionistic gratifications of the therapist, who plays at omniscience and omnipotence, or at being *both* parents in one body to a family of children subject to his control. The "master of ceremonies" role is one example of this reaction.<sup>2</sup> Patients may collaborate all too willingly with this characteristic of the therapist and form a stable group, with gratifications for therapist and patients alike rather than therapeutic progress.

An advantage, however, in the mirror phenomenon, is that the therapist who is alert to this danger, has an even greater opportunity than in individual therapy, to see himself as others see him. When several patients hint at, or openly express, feelings, which overlap in spite of individual differences, about what the therapist says and does, it is not so easy to write them off as "just transference." The therapist has more opportunity for the reality testing of his therapeutic personality and more starting points than in individual psychotherapy for self-analysis of counter-transference.

The writers' experience in training inexperienced group psychotherapists leads them to believe that the use of co-therapists and/or silent recorders in their groups helps to reduce the propensities to pretended omnipotence, and to facilitate insight into counter-transference. However, there is also a counter-transference problem associated with the use of co-therapists or recorders.

A therapist may project his super-ego into the co-therapist or recorder and be inhibited by the resultant expected criticism, or may even misinterpret the co-therapist's interpretations to the group. Such difficulties can be ironed out by frank discussion either outside of, or within, the group.

Something which has not been emphasized as much as the demagogic tendencies of the group therapist, is the reaction formation against these trends. The therapist may be excessively passive as a defense against wishes to dominate and compete. It should not be forgotten that the therapeutic process continues under *optimum* leadership, not complete absence of leadership. The optimum involves somewhat more activity at first than later, and this activity becomes less as the group tradition of carrying therapeutic responsibility develops. There must be some frustration of dependent wishes toward the leader but, if he defaults on leadership completely, there may be chaos, or there may be the emergence of a nontherapeutic patient-leader.

## 2. REACTIONS INHERENT IN SELECTING A PARTICULAR TYPE OF GROUP

Whenever one selects patients to form a group which is homogeneous in some characteristic, there are possibilities that this selection was motivated by neurotic conflicts. This does not mean that there may not also be objective reasons for selecting this group, or that the therapist may not be able to overcome the "defensive countertransference"<sup>10</sup> inherent in this motivation. It does, however, impose a responsibility on the therapist for self-analysis, or analysis with the help of others, as to any neurotic components which might lead to a particular "aim attachment countertransference"<sup>9</sup> which would interfere with therapy.

A group of mothers, a group of fathers, a group of frigid women, a group of alcoholic men, or a group of patients with a common "psychosomatic disorder," for example, may represent a multiple of some key figure in the therapist's past who was a source of trauma and anxiety which the therapist seeks to master by getting revenge many times over, perhaps in a sublimated fashion, perhaps not. A group of young university students may represent the therapist himself at a stage in the past, and he should discriminate between the needs of these patients and what he thought were his needs at the same age. And so on—one could give many

examples. It is enough to make the point of the need for analysis of the motives leading to the selection of the particular group.

### 3. REACTIONS IN RELATION TO INDIVIDUALS WITHIN THE GROUP

Any of the examples mentioned for particular types of groups, and many others, may be presented in the form of an individual in a heterogeneous group, with consequent counter-transference reactions in a therapist for whom such an individual represents a key person. One cannot begin to cover the wide variety of reactions which are possible for therapists to have toward individual patients in a group, either in response to the patient as a whole or to partial aspects of the patient. They may occur at the beginning of the therapy, or in the course of the development of transference reactions by the patients to the therapist and to each other. The writers will present only one example of involvement of the therapist's aggressive drives, and one of involvement of the therapist's libidinal drives, to illustrate the complexities of what can happen in the group as a result of the therapist's responses to individual patients.

*Aggressive drives* of the therapist may be stimulated competitively by a patient who tends to "take over" the group and to give interpretations or other leadership to others in a group—the kind of patient who may be very useful as an auxiliary therapist, unless the therapist responds by acting out his own conflict over aggression. In such a case, the therapist may either "sit" on the competitor in an effort to suppress him, or, he may "lean over backward" against doing so, and give the patient "enough rope to hang himself." The latter course can have considerable repercussions in the group. The other members are frustrated at not getting leadership from the therapist, are envious and angry that "brother" has taken over, and fearful that their own competitive strivings might result in getting "high and dry" themselves and cut off from both parent and siblings. At whatever point in this chain the therapist becomes aware of what has happened, he must take care to clarify the most recent steps before he interprets the initial competitive problem. He acts wisely if he shares the responsibility for what has happened, without excessively blaming others or reproaching himself.

*Libidinal conflicts* of the therapist in group psychotherapy are stimulated in a more subtle fashion by the dependent, "good" pa-

tient, who is willing to talk about symptoms, than by the more openly seductive "siren." The therapist tends to defend himself by ignoring the latter, or else her behavior is interpreted more openly by him or by others in the group. However, the young woman who seeks a close relationship with the therapist by a child-like dependency, or by presenting symptoms, or history, or dreams, or whatever else, may appeal to the therapist, and may, at times, get the therapist involved in a "pairing" which leaves out the other members of the group. Since the therapist seems to be responding in a manner appropriate for a doctor, or a parent figure, the reactions of other patients are more covert, but may involve strong rivalries, both at a sibling level and in response to the unconscious sexual overtones whenever two people are interacting to the exclusion of others. Again, these rivalries may be used to promote insight by the therapist and by others in the group; but if they are allowed to mount, without clarification, or without being reduced by shifting the focus from the individual to the group, both the individual getting the attention, and the excluded members, as well as the therapist, may get caught in a circle of guilt and need for reassurance.

One might go on with other individual examples, such as the passive-aggressive patient who hides self-defeat behind a "winning smile," and stirs up both aggressive and libidinal drives. (Such a patient was dubbed "an all-American boy with pyorrhea" by two co-therapists who were frustrated by his defenses.) These are examples of "induced counter-transference" responses,<sup>10</sup> in which the nature of a patient's problems evokes certain feelings in the therapist and in others in the group. The therapist's job is to be alert to these and to respond in a manner which facilitates a correction of them through the total group dynamics, so that all the patients, and the therapist, are both helpers and persons who are helped.

#### 4. REACTIONS IN RELATION TO ONE'S PROFESSIONAL SUBCULTURE

Finally, it is helpful to be aware of the problems which the psychiatrist, psychoanalyst, psychologist, or social worker, engaging in group psychotherapy, may have when many, if not most, of his colleagues in his own profession may not use this method, or may even look askance at it. Perhaps the group psychotherapist likes this situation, but it has dangers for him and for the patients

whom he serves. These dangers are in two directions: toward the insufficient use of group psychotherapy when it is objectively indicated; and toward its overenthusiastic use, to the exclusion of other methods of treatment, when these would be indicated. These dangers usually make rather for errors in diagnosis and in therapeutic planning than for errors of counter-transference. But they can result in counter-transference errors in the course of group or individual psychotherapy, through a failure to see when a shift from group psychotherapy to individual psychotherapy, or vice versa, may be indicated.

With reference to the psychiatric profession, the psychiatrist is less vulnerable to the dangers described if he does not confine himself to doing treatment only in groups, but maintains his skill at individual psychotherapy or at psychoanalysis, or at using physical adjuncts, such as drugs, so that he does not forget that there is more than one way to help people in trouble. Likewise, when more psychiatrists and psychoanalysts add group psychotherapy to their skills, there will be more flexibility in the selection of treatment plans, and more recognition of the unique advantages, of group psychotherapy for some individuals, at some times. When this latter situation develops, the psychiatrist who is a group psychotherapist will, of course, have less of a problem in relation to his own professional subculture—except when he is the victim of his own need to deviate.

#### SUMMARY

The emotional position of the group psychotherapist has been discussed from four vantage points: reactions derived from the nature of group psychotherapy; reactions inherent in selecting a particular type of group; reactions to individuals in the group; and reactions to using a procedure to which many or most of the therapist's professional colleagues may not subscribe.

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## CAUSES AND TYPES OF NARCOTIC ADDICTION: A PSYCHOSOCIAL VIEW

BY DAVID P. AUSUBEL, M.D., Ph.D.

Addiction to narcotic drugs is one of the most serious but least understood medico-social problems of our time. The grievous lack of public enlightenment about this problem reflects in part its inherent complexity as well as the paucity of definitive research findings dealing with physiological, psychological, and social aspects of addiction. But an even more important cause, perhaps, of both lay and professional misunderstanding of the drug addiction problem is the continuous stream of lurid and sensational misinformation about this topic which appears in the various mass media.

### THE ADDICT'S VIEW

Let us examine first the addict's own view of the cause of drug addiction. According to him, all human beings are equally susceptible to addiction. The unlucky victim need only have the misfortune to be introduced to the drug as a result of abnormal curiosity, chance encounters with addicts and narcotic peddlers, or prolonged illness. Then, once he is caught in the "iron grip" of physical dependence on the drug he is allegedly powerless to help himself. He is obliged to continue using more narcotics "just to stay normal," that is, to avoid the "unbearable" symptoms that ensue when the drug is discontinued.

This dangerously distorted account of the causes of drug addiction is a great comfort to the addict. It puts his illness in the most favorable possible light and also absolves him of all responsibility. Unfortunately, however, he has not only successfully deluded himself, but has also managed, with the unwitting co-operation of the mass media, to foist his understandably biased view on a credulous American public. Physical dependence and withdrawal symptoms are genuine physiological phenomena, and association with confirmed addicts or drug peddlers is the typical way in which candidate addicts are introduced to narcotics. But neither factor explains *why* an individual becomes a drug addict.

### *Physical Dependence*

How credible is the physical dependence explanation? In the first place, although the symptoms of withdrawal are distressing,

they are generally no worse than a bad case of gastro-intestinal influenza, and, in any event, largely disappear within 10 days. Thus, unless other potent satisfactions were derived from the narcotic habit, it is difficult to believe that any individual would be willing to pay the fantastic price of the drug and risk imprisonment and social ostracism merely to avoid a moderately severe 10-day illness. Second, every year thousands of persons with serious fractures, burns and surgical conditions receive opiates long enough to develop physiological dependence, but are nevertheless able to break this dependence quite easily. Third, the dosage of morphine (or equivalent) required to prevent withdrawal symptoms is never more than one to two grains daily. Hence, why will drug addicts take up to 20 grains a day if they take the drug, as they claim to, "just to feel normal"? Fourth, withdrawal symptoms can be adequately prevented and relieved if morphine is taken hypodermically. Therefore, why will addicts run the risk of thrombophlebitis and septicemia by injecting the drug "main-line"—or directly into their veins—with crude, homemade syringes? The answer to both third and fourth questions is that the large dose and the "main-line" route increase the "kick" or euphoric effect. Fifth, new, synthetic opiate-like drugs have been developed which have all of the analgesic and euphoric properties of opiates, but for which withdrawal symptoms are minimal. Nevertheless, the evidence is conclusive that addiction develops just as rapidly for these drugs as for other opiates.<sup>1</sup>

Last, if physical dependence were a significant causal factor in drug addiction, how could we explain the fact that at least 75 per cent of all addicts discharged from federal hospitals start using the drug almost immediately after release?<sup>2</sup> By the time of release, it is at least a year since physical dependence was broken. If addicts are really so terrified by withdrawal symptoms, why should they start developing the habit all over again after suffering the symptoms once and then escaping their clutches?

#### MULTIPLE CAUSALITY IN DISEASE

Generally speaking, research on drug addiction has been hampered by the same type of faulty thinking that has plagued the investigation of the causes of such other complex disorders as cancer, tuberculosis and juvenile delinquency. This is the error of assuming that since the disorder in question *appears* to be

identical in all individuals, it must necessarily have the same *single* cause in all instances. Actually, there are many different kinds of drug addicts, and the causes of drug addiction are multiple and additive in their impact rather than mutually exclusive.

As in most other diseases, the causes of drug addiction include both *internal* factors originating within the affected individual (e.g., hereditary susceptibility) and *external* factors originating within the environment. Each type of factor may be further categorized with respect to whether its impact occurs immediately prior to, and is essential for, the appearance of the disease (*precipitating*), or is operative over a longer period of time and merely contributory (*predisposing*). In tuberculosis, for example, hereditary susceptibility to the inroads of tubercle bacilli is the predisposing internal cause, and temporary lowering of general resistance (as in overexertion or exposure to extremes of temperature) is the precipitating internal cause. Comparable external causes would include overcrowded living conditions, on the one hand, and actual exposure to an adequately large dose of tubercle bacilli, on the other.

It makes little sense, therefore, to talk about *the* cause of tuberculosis. Exposure to a reasonably large dose of virulent organisms is a necessary causal factor but is rarely a sufficient cause in the absence of particular hereditary susceptibility to tuberculosis, depressed standards of living, and transitory lapses in general resistance to disease. In any given case, one particular factor may overshadow all others and thus provide a spurious appearance of single causality; but this neither guarantees that this same factor will be equally prominent in other cases nor excludes the operation of other factors in the same case. All we can say in this regard, is that if any one of the relevant causes is especially salient, the other contributory factors are less necessary to bring about the disease. If one individual, for example, by virtue of his heredity, happened to be highly susceptible to tuberculosis, whereas his neighbor happened to be highly resistant to this disease, the former would obviously succumb to a much smaller dose of tubercle bacilli than would be necessary to strike down the latter. It also follows that both the severity of the disease and the outlook for recovery would vary in accordance with the relative prominence of the various casual factors.

## MULTIPLE CAUSALITY IN DRUG ADDICTION

The causal picture in drug addiction is quite analogous to that just described for tuberculosis. Availability of narcotics (that is, exposure to addicts and drug peddlers, or, in the case of physicians and others, even more direct access to the drug) is the *external precipitating* factor. No matter how great an individual's susceptibility, he obviously cannot become a drug addict unless he has regular access to narcotics. The factor of relative availability explains why the rate of addiction is so much higher in slum areas and among members of the medical and allied professions than in middle-class neighborhoods and among other occupational groups. To account for the higher Puerto Rican addiction rate in comparably exposed Negro and Puerto Rican sections of New York City's Harlem slum area,<sup>3</sup> and for the much higher addiction rate in China than in Japan,<sup>4</sup> one must invoke a major predisposing factor, also of environmental origin, namely, degree of community or cultural tolerance for the practice.

But *external* factors alone cannot explain all of the known facts about the incidence and distribution of drug addiction. In a given slum area of uniformly high exposure to and tolerance for the drug addiction habit, why is the practice limited to a relatively small minority of the residents, and why do male adolescents constitute such a disproportionately large percentage of the affected group? Why do some addicts originate in middle-class neighborhoods despite little exposure to narcotics and strong community disapproval of the habit? To explain these facts, we must turn to the important internal factor of differential susceptibility. In the same sense that individuals are not equally susceptible to tuberculosis, they are not equally susceptible to drug addiction.

## TYPE OF ADDICTION

*Maturational Deficiency.* The most serious, and prognostically least hopeful, variety of drug addiction occurs among individuals who fail to undergo adult personality maturation, that is who fail to develop the long-term drives and corresponding motivational traits characteristic of normally mature adults in our society. Such motivationally immature persons are typically passive, dependent, irresponsible, lacking in perseverance and self-discipline, and preoccupied with achieving immediate, pleasurable self-gratification. They are unconcerned about marriage, raising a family, socially

useful employment, vocational achievement, financial independence, and constructive service to the community.<sup>5</sup> The euphoria (objectively unwarranted feelings of ecstasy, well-being and self-confidence) induced by narcotics has uniquely efficient adjustive value for them. It provides immediate and effortless pleasure and dulls their self-critical faculties, thereby enabling them to feel supremely contented with their immature and inadequate adjustment to life's problems. Hence, since few other adjustive mechanisms are able to compete with drugs in attractiveness to persons possessing this type of personality structure, the disorder tends to be chronic, and the outlook for recovery is poor.

What are the sources of the motivational immaturity that constitutes the internal predisposing factor in drug addiction? Apart from hereditary proclivities toward such personality traits as passivity, self-indulgence, and excessive need for pleasurable self-gratification, the principal causes of motivational immaturity are particular kinds of unsatisfactory parent-child relationships. Considerations of space do not permit a full discussion of this topic. But examination of the kinds of relationships that drug addicts as children and adolescents have had with their parents reveals several typical patterns: (1) the extremely *overprotecting* parent, who shields the child from all independent experience and all possibility of failure so that he never gets the opportunity to set mature goals for himself or to act independently; (2) the extremely *underdominating* parent, who makes no demands on the child for mature behavior and leads him to believe that he is a specially privileged person whose needs will always be satisfied by others; and (3) the extremely *overdominating* parent, who imposes excessively high goals on the child, thereby inviting complete sabotage of the goals of adult maturation as soon as the child can escape from parental control.<sup>6</sup>

### *Reactive Addiction*

Reactive addiction is the most common type of addiction found in the United States today, having increased spectacularly since the end of World War II. It is a transitory, developmental phenomenon, occurring principally among slum-dwelling adolescents with essentially normal personalities. The adjustive value of drugs for these individuals is simply that they provide an outlet both for the exaggerated rebelliousness and defiance of conven-

tional norms (which is not uncommon among American adolescents generally), and for the particular aggressive attitudes associated with membership in an underprivileged and often ethnically stigmatized segment of the urban population. These precipitating internal factors are further compounded by such external factors as the ready availability of drugs, high community tolerance for addiction, and coercive pressures from addict associates in the closely-knit predatory gangs of the urban slum. Dabbling or experimenting with drugs has no unique adjustive value for the tensions and attitudes operative in this context. It is just one of many possible nonspecific ways of expressing aggression, hostility, nonconformity, and identification with deviant age-mates. Like juvenile delinquency, therefore, this type of addiction gradually diminishes and is eventually discarded by most of the reactive drug users, with the approach of adult life, as normally mature family and vocational interests assert themselves and as adolescent identification with deviant norms correspondingly declines.

A difficult problem in differential diagnosis is posed by the fact that the motivationally immature type of addict is found most commonly (although by no means as exclusively as is the reactive type of addict) among adolescent and young adult males in urban slum areas. This is hardly surprising, when one considers that motivational immaturity is no more rare in such areas than elsewhere, and that the actual development of addiction in highly susceptible individuals is further abetted by adolescent stresses, gang influences, racial and social class tensions, social demoralization, high availability of narcotics, and high community tolerance for the drug habit. How then does one distinguish between these two basically different types of addicts, both of whom are often represented in the same gang?

Data collected by the Research Center for Human Relations of New York University<sup>7</sup> suggest several feasible criteria for differential diagnosis. Motivationally immature addicts tend to use narcotics more regularly, in larger quantities, and more for their adjustive values than "for kicks." They also tend to manifest more serious and deep-seated personality problems, to be peripheral rather than active members of delinquent gangs, and to participate more in the remunerative, criminal ventures of the gangs than in their athletic, heterosexual and gang warfare activities. Reactive users, on the other hand, are typically week-end

"joy-poppers" who much more rarely take the drug regularly enough or in sufficient quantity to develop physical dependence. They are more likely to be delinquent before addiction, to come from the economically more depressed homes in the neighborhood, and to use drugs either to conform to age-mate standards or as just another nonspecific means of expressing antisocial attitudes. After the age of 18, the reactive drug user tends to abandon both his active, predatory gang interests and his casual use of drugs in favor of more mature, conventional concerns with vocation and family; but the motivationally immature habitual user retreats further from normal adult adjustment into drug-induced euphoria.

#### *Miscellaneous Varieties of Drug Addiction*

A relatively rare form of narcotic addiction is found sometimes among individuals suffering from neurotic anxiety and depression. These addicts, usually professional persons who have easy access to the drug, tend to use small, stabilized doses of opiates for the *sedative* rather than euphoric effects. Possessing strong achievement drives and normally mature motivational traits, they value the drug solely for its anxiety-reducing properties and for its ability to soften the unreasonably harsh and critical view that anxious and depressed individuals take of themselves. But since many other adjustive mechanisms (e.g., rationalization, compensation, delusion, fantasy, phobia, compulsion) are available, and since the barbiturates and tranquilizers are, in any case, both more efficient and legally accessible for the desired purposes, this type of addiction is becoming increasingly more rare. Drug addiction also occurs occasionally among certain vicious, remorseless criminals, the aggressive antisocial psychopaths, who use the addiction habit merely as a nonspecific means of expressing hostile and destructive personality trends.

#### SUMMARY

The addict's dependence on continued use of narcotics to avoid withdrawal symptoms is not a significant factor in causing drug addiction, even though the drug addict has been amazingly successful in deluding both himself and the American public into believing that it is the primary causal consideration. Physical dependence cannot account convincingly for the surplus dosage and intravenous route habitually taken by the confirmed addict,

or for the latter's willingness to risk social ostracism and incarceration just to avoid a moderately severe 10-day illness. Neither does it adequately explain the recurrence of addiction long after physical dependence is lost, nor the strong addicting-potential of new opiate-like drugs which give rise to only minimal degrees of physical dependence, nor the ease with which normal persons are able to overcome the physical dependence on narcotics which they may inadvertently acquire during the course of prolonged illness. All of these facts suggest that susceptibility to drug addiction is variable rather than uniform, and that addicts use opiates primarily for their euphoric properties.

The causes of drug addiction are both multiple and additive in their impact. As in most other diseases, they include factors originating both within the person (internal) and within his environment (external), and each category in turn may be further divided into predisposing and precipitating causes. The major external and necessary precipitating factor is the ready availability of the drug, a factor which is reinforced by the predisposing environmental factor of high community or cultural tolerance for the practice. These external factors are sufficient to induce the disorder in individuals who are highly susceptible to addiction.

Susceptibility to drug addiction (the internal factor) is largely a reflection of the relatively great adjustive value which narcotic drugs possess for potential addicts. This adjustive value is most specific and efficient in the case of those individuals for whom the euphoric properties of opiates are most attractive. These are persons who manifest the internal predisposing factor (failure to develop the drives and motivational traits characteristic of normally mature persons in our society). This internal predisposing factor (motivational immaturity) is itself largely an outcome of particular kinds of unsatisfactory parent-child relationships, as well as partly a reflection of various temperamental traits of hereditary origin.

Susceptibility to drug addiction is less marked when the euphoric effects of opiates have less specific and efficient adjustive potential. This occurs when the susceptibility reflects internal precipitating factors of a more transitory nature, such as adolescent revolt against conventional norms, gang pressures, and attitudes associ-

ated with residence in a socially demoralized urban slum or membership in a racial minority group.

On the basis of the relative prominence of these various casual factors, it is both possible and diagnostically important to distinguish between two major and essentially different types of drug addicts. In instances where increased susceptibility to addiction is indicative of long-standing motivational immaturity (the internal predisposing factor), the highly specific and efficient adjustive value of the drug makes for a chronic type of disorder with a very poor prognosis. Where external causal factors are more prominent and internal factors are of a more temporary (precipitating) nature, the adjustive value of the drug is less specific and efficient, and the resulting (reactive) type of addiction accordingly tends to be a transitory aberration similar to juvenile delinquency. Both types of addiction, however, the motivationally immature as well as the reactive, are found most commonly among adolescent males in the urban slums. This is because motivational immaturity occurs just as frequently there as elsewhere, and because all of the other internal and external causal factors (the various developmental and social stresses, the high availability of the drug, the high community tolerance) tend to converge on teen-age boys who reside in such areas.

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## II. PRIMARY GAIN: THE GAME OF ILLNESS AND THE COMMUNICATIVE COMPACT IN THE BORDERLINE PATIENT\*

BY JORDAN M. SCHER, M.D.

The purpose of this paper is to raise the question of nontreatment, rather than treatment, of a group of patients who are admittedly and obviously severely ill. This group is one for whom treatment seems to serve the cause of illness rather than health;<sup>2, 3</sup> in fact, very often they succeed in functioning relatively efficiently only in its absence.

The diagnosis of patients in this group is determined more by the course of illness than in terms of the psychodynamics they present. They are often called hysteric or obsessive on initial or early contact. They are progressively viewed as representing inadequate, primary narcissistic or infantile personalities dynamically; and, clinically, they are psychopaths, schizophrenics or character neurotics. Many definitions of this group appear.<sup>4-9</sup> Perhaps a new word, *seists*,\*\* might be employed to group such patients under one heading, in the sense that their total orientation is in terms of a framework of self.

They characteristically make pilgrimages from analyst to analyst, or remain with one analyst to achieve a steady state of interminable analysis.<sup>10</sup> Many among them will seek recurrent, or achieve chronic, hospitalization.<sup>11</sup> Despite spending long years in the hospital, they usually do not deteriorate, and only go through transient and relatively brief periods of disturbed behavior. It is surprising how well preserved many of these patients appear after prolonged institutionalization.

Two case examples follow:

### *Case I.*

A 25-year-old unmarried white woman was seen in an out-patient clinic.† Four of her six siblings and her father had spent some time in a mental institution. She had had three previous therapists for periods of six months to two years. At the time she was first seen, she had been on thorazine and seconal continuously for six months. She was agitated,

\*This paper is a continuation of the paper, "Diffusion of Communication and Role Exchange in the Treatment of Schizophrenia."<sup>1</sup>

\*\*Seism, seist—from the Latin *se*, self, and the suffix *-ism*.

†University of Maryland Psychiatric Institute, 1955.

vague, uncertain, rambling, and talked primarily of her relationship with her former therapist. It was decided not to interfere with her self-medication, or to re-fill it, leaving this in the patient's hands. Over the course of four weeks' therapy, the patient gradually discontinued the medications herself.

She had been maintaining a job as a clerk for the preceding three years, had had many difficulties with other personnel members; she had often been absent; and she showed progressive withdrawal. She complained that all of her friends were married, that her acne (which was very mild) inhibited her socially, that her talents and work were not properly credited or supported. She was a well-groomed, very well-dressed, attractive woman who went on periodic "clothing binges."

In the second month of therapy, following an hour in which she demanded, in direct and indirect ways, that the therapist demonstrate his interest in and love for her, she produced, just before leaving, a razor blade from her pocketbook and left it with the therapist. She began at this time to insist that she be hospitalized, since she was aware that the therapist had other patients he had hospitalized on the premises. He refused to hospitalize her. The patient appeared at the clinic several times without appointments instead of going to work; she telephoned at least once daily.

Her conversation during the hour for psychotherapy had several characteristics. She insisted on overtalking the therapist, or tried to extend the hour indefinitely, or arbitrarily set her own time of coming and going, or insisted that because of work or other engagements she would have to change the appointment time. She often arrived, telling the therapist that she had something "very important," "very painful," that she had to tell him or wanted to say, but invariably told of nothing either personal or important. She often implied that certain things were her business and not the therapist's, parried all his questions or refused to answer them. Whatever the therapist offered by way of interpretation was "not it" or "not quite it."

After two months of such interaction, the therapist received an early morning call from another hospital where the patient had appeared giving the therapist's name and hospital as reference. It was felt by the receiving clinic that the patient showed signs of an acute schizophrenic reaction. She was referred to the therapist, who, after keeping her in the admission ward for six hours, was prevailed upon to admit her.

On admission she was, at his request, and despite staff demur, placed upon a ward of convalescing and neurotic patients. She "deteriorated" rapidly, soiling herself, tearing up her clothes, saying she was "in outer space," "on a space ship," "hearing voices." She felt that the "exit sign" was the "way to Hell." She alternated between agitated excitation, vague-

ness, appropriate but noninformative behavior, pseudo-affection, marked aggressiveness and destructiveness.

Her mother and a sister recently released from the hospital, and whom the hospital had given up, visited the patient and insisted that there was nothing wrong with her. She was only "lazy," "putting on an act," and "needed to be fattened up."

During the course of the next month and a half, the patient progressively dropped her overt psychotic symptoms and began to go out of the hospital on privileges. She managed, however, to produce a number of razor blades she bought at drugstore counters, and said she consumed many sedatives specifically denied her by the therapist, and on one occasion she picked up a sailor, and went by bus to a nearby city, but returned the same night.

The therapist attempted to get the patient to discuss these things and to interdict them but he only succeeded in getting apologies and promises "not to do it again," followed by repetitions. Despite this, however, the patient generally seemed to be improving and the frequency of such behavior did diminish. No privileges were taken away from her; and she was encouraged to return to work, which she did.

After three months of progressively more orderly function and no greater insight into her problems, the patient discovered that the therapist was planning to leave the hospital. At first she insisted that he take her along, which he refused to do on the grounds that her progress was such that she should be able to function adequately on the outside without his aid, by the time he was scheduled to leave. She hesitated, but seemed to accept this. The following week-end, while the therapist was away, she threw a tantrum which was judged to be a schizophrenic disorganization, and she was removed to the maximum security area and secluded.

On the therapist's return, she said, "This will get even with you," and said that she hated him and would kill herself or him if she got the chance; and that she was "obviously too sick" to leave the hospital. The therapist was urged by his colleagues to commit the patient, which he refused to do, saying that he felt the patient had enough ego strength, despite the demonstrations, to function in the outside world.

It was decided to discharge the patient in her own custody, and she left the hospital with her mother. The therapist advised her to stay away from doctors, medications and hospitals. She called the therapist within an hour of discharge and said that she was going to commit suicide and that it was the therapist's responsibility to do something about it and stop her, or it would be "his fault." He suggested that she was responsible for herself, and that if she committed suicide, she "would be the loser," not he.

The patient did not get in touch with the therapist again for about a month. Then she called one evening to thank him for his advice and help and to have him send her some money she had given him for safe-keeping. He advised her that her mother received the money on her discharge. She said she was feeling much better, had seen no doctor, and taken no medication. She had returned to her job. Three months later she called again to thank him, and subsequently for the next three years, by way of sending him cards for the meetings of the local mental hygiene society, of which she was secretary, informed him periodically that things were going quite well.\*

#### COMMENT

In this case, the patient attempted to establish a "compact," which was resisted by the therapist at many points along the way, and finally directly blocked. Despite the therapist's efforts, a great number of environmental supports had promoted the patient's attempt to establish this "compact": medications, acting out, medical intercession, professional opinion and the definition of illness itself.

#### Case 2

The second case is that of a 36-year-old divorced man who had had a full pension from the service for 10 years following seven months of duty. He had a 19-year-old son whom he was supporting through college with his pension money. He had, on numerous and protracted periods, been in and out of one of the government hospitals, and was chosen by a therapist at the National Institutes of Health for a study of depersonalization and LSD. On transfer he refused to submit to the LSD, but was permitted to stay anyway and was treated by psychoanalysis for approximately two years, even during a brief period of transfer to the original hospital, at which time the therapist visited him there.

The patient was a very charming, engaging, attractive man of medium height who had kept at his elbow a well-thumbed copy of the Hinzie and Shatsky *Psychiatric Dictionary*. He had become such an established figure in the hospital setting that he had a door knocker on his door, and was considered—hostilely—by the staff to be the "real administrator" of the ward. In a conflict involving a head nurse's role regarding the patient, she was permitted to resign. One of the nurses had acted as a witness at the wedding of the patient's brother. A general feeling of alternating warm closeness and distant fear existed between the patient and the staff. He maintained an "s— list" of those who were not on his side, together with

\*It has now been more than six years since this patient was last seen. She has sent cards to the writer annually. Two years ago, she reported her marriage and, last year, the birth of a daughter.

a list of friends, and revised them almost daily, at such a pace that the staff was never sure when and with whom he would choose to be hostile or warm. This gave a feeling of great uncertainty in dealings with the patient.

He maintained a car on the base and would go out almost at his own behest. When drunk, he was aggressive, and on one occasion smashed an ash stand over the head of a fellow-patient. The ward personnel developed very mixed feelings about the patient.

After two years of great difficulty and uncertainty concerning this patient, his therapist also became the ward administrator. Following one episode when the patient returned to the ward drunk and wielding a length of pipe, the staff, feeling that the patient was quite uncontrolled, requested stronger measures by the administrator-therapist. It was decided that the patient should be restricted more, allowed out only when accompanied, allowed only restricted use of his car and restricted trips to bars. Within hours of the new orders, the patient eloped, through what were called the "revolving doors" of the closed ward.

The nursing staff, very alarmed, threatened, and feeling that things were out of hand, requested that something definitive be done; many threatened to resign if nothing were. Requests were made among the medical staff for suggestions, and none in particular were forthcoming. It was decided to split the administrative function from the therapeutic again; and since no volunteer presented himself, the clinical director requested that the writer serve as administrator, a task which he accepted.

In line with the principles cited in the present paper, the new administrator in the first interview with the staff, said, "Patients such as these are better off without treatment, and out of hospital, so that the demands of society can support their efforts at functioning. However, in the hospital situation, such patients must be 'limit set' and must learn to get some sense of where they stand in relation to the rights of others. They practise a kind of 'divide and conquer'; and this can only be dealt with by presenting a common front toward them in this setting. It will be my job to take care of his ward needs and to refer him to his therapist for conversation about his psychological needs. The staff will also refer the patient to his therapist if he wishes to talk about personal matters. The staff will refuse to engage in discussing their own affairs with him, if he requests personal information. He is a patient, not a confrere."<sup>1</sup>

The patient was seen with the assembled ward personnel so that the previous communication problem might be avoided. The patient was informed of the terms of the situation, and agreed to abide by them. For about three weeks, except for minor difficulties, he complied with the rules. It had been his custom to prescribe continuous "tubs" for himself when he was "anxious," but he had refused to permit the cover to be put on

and had decided the duration of the bath and other details. It was decided by the new administrator that packs would be prescribed, if at all, by the medical staff for his "anxiety" and that they would be given according to the usual hospital routine.

After three weeks, the patient could no longer tolerate not having control of the situation, and he eloped again. He had been told that if he were to do so, following the assignment of the new administrator, he would have to be returned to his referring hospital. However, on his voluntary return two days later, and in view of his therapist's urge to continue with him, it was decided that greater control over him might be possible if he were to be committed. The patient's brother was seen in an effort to achieve a commitment, but he was not co-operative. While the staff was debating what to do, the patient, on re-entry to the ward, had been placed in seclusion and was being gradually permitted more ward privileges. However, his door knocker was removed from his previous room and another patient was moved into it.

A week after the patient's return, a lawyer appeared on the scene with the suggestion that, since the patient was not committed, he must be released immediately, despite the fact that he was a voluntary patient. This had been previously arranged with his brother, it would seem.

The patient was asked his preference; he elected to leave. He was told he would not be allowed to return to the hospital. He accepted this. Finally he was advised by the administrator that he should avoid medications, doctors and hospitals, and should get a job. He agreed. They shook hands, and the administrator wished him luck. The administrator advised the therapist that he not treat the patient as an out-patient, as the patient himself had suggested, and the therapist had been tempted to do. The therapist agreed.

On several subsequent occasions when the patient attempted to re-enter the hospital, the administrator recommended against accepting him, repeating his terminal suggestions. The patient returned once or twice to visit, and appeared comfortable. At the time of writing (1957), he had been out of the hospital one and a half years, the longest continuous period in 12 years. He had gotten a job, had remarried, and seemed to be getting along well.

#### COMMENT

This case represents a situation in which the patient had established a pathological "compact" with the therapist. However, the terms of this situation, although comfortable for the therapist at least, were progressively less comfortable for the ward staff.<sup>1</sup> Only when the pressures of the total situation were such that a crisis was precipitated, did any serious questions concerning the

patient's role in the hospital system develop. The opinion of the new administrator that the patient had been permitted too much license in the situation and should be given a clearer picture of his place in the hospital scheme was greeted by the medical staff with raised eyebrows, incredulity and open hostility. The nursing staff said in effect, "That's what we have been saying all along." Many individuals at all levels participated in the diffusion of communication and role exchange, and all quite innocently. The patient, by succeeding in his conscious or unconscious endeavors on the ward, skillfully perpetuated his position and avoided therapy. It was striking that no suggestion of the sort made had occurred previously; but perhaps this can best be understood in the context of the prevailing permissive philosophy present in this setting. In fact, one of the explanations offered for the situation was that the patient had been given a great deal of "love" by the staff, so that "their expectations of him were too great for him to meet." In line with this, it was felt that "he might eventually after a good deal more therapy be able to return something for the staff's efforts." His response without further therapy, however, was perhaps more impressive.

#### DISCUSSION

Several questions arise regarding such patients. What is the nature of such a self-perpetuating process as theirs? What are the components in the treatment situation itself which promote the negative aspects of this situation for the patient? What are the roles of the hospital, the analyst, and the patient? How might these best interact to interrupt the vicious cycle and safeguard the interests of each?

In such a situation, the hospital may be viewed as the abstract representation or cultural instrument of the conscious and unconscious interaction between the analyst and the patient. This interaction is less an open *contract* in the usual sense than a tacit pathological *compact*; the act of relating becomes an end in itself; the therapeutic situation degenerates into a game, where the moves achieve a *maximum of circularity and isolation from the events of the everyday world*. One patient said, "It's like living in two different worlds. One world is here and the other outside, and the two have nothing to do with each other." For this patient, the analytic

hour was the truly concrete, real world, and the period between represented only empty space.

The compact, which is largely unconscious, tends to determine complementary roles for analyst and patient. The latter agrees to produce a plethora of symptoms, a host of traumata, and elaborate and most exciting psychodynamics. The analyst provides a ready and sympathetic ear, and an arena, such as his office or the hospital, in which the drama may be played out. He also supplies a set of aphorisms to provide clichés that the patient can use for those more skeptical about his situation outside of this setting. For example, the patient may be content with the verbalization that "his mother is responsible for his situation," a phrase which may be repeated interminably and is patently meaningless for him.

The existence of such a pathological communicative compact is indicated when the patient persists in behaving entirely out of keeping with the degree of insight he verbalizes. Another clue to such a situation appears in the patient whose symptoms have a localized and directed quality. In this event the appearance of the doctor on the ward is the signal for a distinct change in the patient's behavior in the direction of greater symptom production and in an acceleration of the tempo of his acting out. The nursing staff may also participate, as described in the second case.

How does the compact achieve its fixity? The patient may be said to bring into the situation an intense "oral dependency" and his pleasure in having a captive audience. The analyst must bring his contribution to the situation also. To describe his part as a function of countertransference would be to beg the question. At an operational level, his contribution may be considered in terms of his behavior. The extent to which one individual can influence the behavior of another in an interactive situation is striking. The passive, interested audition, by the "rules of the game," tends to evoke this behavior.

Silence and minimal activity of the analyst convey to the patient either approval of his performance or a lack of conviction on the part of the therapist that the situation really is as the patient describes it. The analyst may actively promote a patient's disturbing behavior by asking to hear more about a particular aspect of the patient's problem. It can be demonstrated that quite incidental behavior on the part of subjects may be evoked by the

planned but seemingly inadvertent behavior of an experimenter.<sup>12</sup> An actual selection and guiding process, unconscious though it may be, develops in the course of analysis and of offering interpretations. Certainly associations on the part of either analyst or patient may result from apparently minimal actions of the other, such as intonation patterns, to say nothing of such influences at a conscious level.

Thus, there are two related themes in the therapeutic process. The first concerns the material involved in a sort of *selective interchange* in terms of what the patient brings into the therapy situation and how this is handled by the therapist. The second concerns the kind of commitment entailed in the communicative pact, and its meaning beyond the realm of immediate interactive strategy in its setting.

The therapist may ignore, not hear, or select, material to be developed and interpreted. The patient may omit, disagree, demur, and even evade, the pathological agreement. Thus, the actual range of interactive behavior becomes highly restricted and selective. As consensus is approached, an even greater limitation is imposed: A "wording out," rather than acting out, ensues.

In such a situation a kind of communicative solidarity develops which is conspicuously divorced from the events of everyday life. This frequently occurs with the manic patient. A walled-off consensus, without validation or extension into the broader range of daily experience, is not necessarily a dissatisfying experience for patient or therapist.

Communication becomes an end in itself rather than interaction toward growth. The context thus is quite aside from anything therapeutic. "Primary gain" is evident.\* A steady state of mutual communication, apart from the demands and vicissitudes of reality, may go on indefinitely. Many of the features of the analytic situation reinforce such a self-contained system.

When a threat to the security and continuity of the communicative compact develops, the patient may break off the relation-

\*The term "primary gain" is used here to point up the fact that the process described is not only an end in itself, but may actually be a product of the therapy situation. It may in effect be an artifact of the intervention procedure, particularly since discontinuation of therapy—in some cases at any rate—seems to dispel the "primary gain" problem. "Secondary gain" in the ordinary analytic sense appears more of an outgrowth of the process of illness than of the process of therapy, and is less an illness in itself than a concomitant of illness.

ship with the therapist altogether, only to take up one with another on the same terms.

The features of such a compact lead to recurrent hospitalization, particularly where the patient can afford expensive retreats. Adolescence is thereby prolonged indefinitely, and responsible adulthood is forestalled while an interminable analysis wends its way.

The hospital may gain from the practical standpoint of monetary support; the analyst in terms of an object for paternalistic leanings and psychological study; the patient in terms of being an "interesting case," amusing the doctor and evading the responsibility for growing in the world at large. In a certain sense, the experience of illness is a full-time job for the patient.

#### CONCLUSION

One is faced with a serious question: Is the *declaration* of the inability to handle the outside world sufficient reason for either therapy or hospitalization? May one not thereby stunt the growth of an individual whose self-doubts lead him to consultation? Surely the growth potential of everyone who seeks therapeutic attention cannot be really so meager if left to a person's own devices as is implied by the readiness with which people are taken into therapy. Often, apparently floundering, severely dependent patients, incapable of responsible decision or independent action and possessed of extremely weak "egos," when they neither could continue analysis nor afford hospitalization, regrouped their resources or re-evaluated them and found that a fairly adequate adjustment could be made.

Such patients, when forced to employ their own resources, have shown conspicuous ability to do so; this is exemplified well by the experiences of soldiers in wartime.<sup>13</sup> For these people, the cessation or absence of therapy promotes an adjustment which the primary gain of the communicative compact only inhibits.

Is not the limited growth that the patient might achieve without therapy to be preferred to the addiction he may develop as long as he can afford treatment? If this addiction is permitted to progress, the patient abnegates a moderate existence for the chronic invalidism of infantile or schizophrenic reaction patterns and becomes a "primary gain" cripple.<sup>14</sup>

The therapist and the hospital actively shape the destiny of such an individual and may contribute to his childlike irresponsibility.<sup>15</sup>

It is not enough to write off a patient's behavior on the basis of uncontrollable id impulses. Is it wise to attempt to take such patients to too profound a level of oral dependency as in intensive "depth" therapy? "Early ambulation," in the surgical phrase, with perhaps enforced and progressive propulsion into the realm of action, is preferable to the entombing inanition of the communicative compact. Words in a therapy situation for such people seem more a "ticket of admission" than an instrument of analysis or maturation. Indulging their insatiable appetite for therapy is contraindicated. Maintenance in an active functional setting, with a minimum of occasion for "wording out" in the communicative game, is in order.

Just as it is becoming clearer that there are those for whom intervention is the therapy of choice, it must also be recognized that there are those for whom it is not. Nonetheless, such patients may succeed in achieving a moderately functional and satisfying life for themselves if encouraged to do without therapy.

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## SUICIDE ATTEMPTS OF PUERTO RICAN IMMIGRANTS\*

BY EDGAR C. TRAUTMAN, M.D.

A careful study of the sociocultural and psychological problems associated with immigration has revealed a causal relation between a frequent form of suicide attempt on the part of Puerto Rican immigrants and the particular conditions under which these people find themselves living in the City of New York. Most of the persons studied came to New York in the past two decades, and all are members of the lower economic class. Their specific social problem is the need to adapt to a new environment and a new way of life.<sup>1-3</sup>

A high rate of admissions of Puerto Rican suicide cases prevails in all city hospitals serving this population group. For example, between June 1957 and December 1958, Lincoln Hospital, New York City, admitted a total of 131 suicide-attempt cases. Out of this number, no less than 93 persons (71 per cent) were Puerto Rican immigrants. The remaining 38 (29 per cent) were mainland-born Americans.

This high percentage of Puerto Rican suicide-attempt admissions exceeded the Puerto Rican participation rate in the total population of the hospital, a rate which has fluctuated between 55 per cent and 60 per cent of the total in the past five to seven years. While the 38 mainland-born cases included a good many psychotics, particularly in the older age brackets, the Puerto Ricans belonged almost exclusively to the diagnostic category of nonpsychotic hysterical reaction, and were all rather young. This factor indicated that we were dealing with a suicide problem of a specific character.

All the Puerto Rican patients followed the suicide pattern which the writer has termed "the suicidal fit."<sup>4</sup> It is an act in which a person, in a state of intense emotional excitement, suddenly runs from the scene to another room, snatches whatever poison is at hand and swallows it. The whole episode in many cases, is brought on by an angry verbal argument with another person. These swallowers of poison were highly emotional and had usually

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suffered from emotional stress, with recurrent crises for quite some time before the suicide attempt.

In the present study, the writer was particularly interested in three questions: 1. Was the suicide act in its technical aspects modified by the facilities offered by, and the customs of, the environments in which the patient lived now and in the past? 2. Was there a time-specific relation between the frequency of suicide attempts and the date of immigration? 3. What were the psychological difficulties that gave rise to an atmosphere conducive to suicide and in what way were they connected with factors of the immigration situation?

The variety of chemicals used in the suicide attempts was an impressive feature of the environmental situation. In compiling a list of all chemicals used in all available cases, the research was not confined to Puerto Ricans alone, since the specific poisons reflected an aspect characteristic of the surroundings, rather than of the person involved. Included in Table 1, therefore, are Puerto Ricans and others, psychotics as well as nonpsychotics.

There are 123 cases represented, showing the whole gamut of household chemistry of a 20th century home. The chemicals swallowed were taken either from the medicine chest or the kitchen. It is significant that in 42 cases sleeping pills were used, more than any other chemical, indicating how much in the way of barbiturates is to be found in American households and how sleeping-pill-con-

Table 1. Chemicals Used in 123 Cases of Attempted Suicide

Poison From Medicine Chest					Poison From Kitchen Cleansing Products, etc.	
	Sleeping pills	"Harmless" drugs, including aspirin, cough medicine, asthma tablets Vitamin tablets	Antiseptics including iodine Potassium permanganate Mercurio- chrome Peroxide	Liniment Rubbing alcohol	Detergents Washing soda Lysol Lye Cleaning fluid Creosote Benzene	Clorox Rat poison DDT Other bug spray
Females	32	14	15	6	23	6
Males	10	3	7	3	4	—
Totals	42	17	22	9	27	6

scious in our age of drug addiction even the most unsophisticated portion of the population seems to be. In addition, other medical drugs and antiseptics were also popular. In the kitchen in this type of suicide attempt, cleaning fluids and detergents were apparently preferred to the slow-working gas poisoning.

It is a matter of conjecture what the Puerto Rican patients might have done in the same emotional crises, had such an abundance of chemicals not been available to them. Would they have used more violent methods, like the woman who jumped out of the window after her husband snatched the pill bottle from her hand? Or would they have converted their excitement into a so-called *ataque nerviosa*, a behavior reaction which is very common on the island of Puerto Rico but rarely displayed by Puerto Ricans living in New York.<sup>12</sup> This attack, which is also a hysterical and automatic escape from emotional pain, is the equivalent of the "suicidal fit." In *ataque nerviosa*, the excited patient does not run away, but he withdraws from the scene by falling to the ground; and, instead of poisoning himself, he finds oblivion in a deep stupor of hysterical nature. The *ataque nerviosa*, in its psychodynamic aspect, is the harmless island variety of the "suicidal fit." In both versions, the behavior pattern is colored by local customs and influenced by the technical situation at hand.

The importance of the environment became more evident with further study of the question of what might have happened to the patients after taking poison if they had not been living in New York. Of those who took phenobarbital, some arrived at the hospital in semicomatose conditions, others in deep and serious comas. Since, in all cases, immediate antihypnotic therapy was instituted, none of the phenobarbital cases proved fatal. How many might have died in the absence of the well-organized and alert rescue service of the hospital cannot be estimated. Those who took nonbarbiturate chemicals were brought in with stomach pains or vomiting attacks and were treated accordingly. One person who had taken rat poison died in the hospital.

Generally speaking, there can be no doubt that the outcomes of suicide attempts are, in many cases, determined by factors in the culture in which the attempt is made, as well as by the presence of available rescue facilities that are a matter of public knowledge. Statistics which classify suicide attempts as serious or not

serious, according to outcome, fail to take into consideration the decisive role that environmental factors play in outcome.

To ascertain whether or not the incidence of suicide attempts bore any relation to the immigration situation of the patients, the writer questioned 80 survivors of such attempts about the duration of their residence on the mainland. It appeared that suicide attempts were less frequent in those who had been living here for comparatively longer periods than in those who were here only a short while. Table 2 shows that in the immigrant group of the past seven years,\* the suicide figures, totaling 48 cases, were higher than in the group of eight to 14 years, totaling 20 cases.

When one goes back beyond 15 years (to the period during and before World War II), the figures taper off, particularly in the male column. However, one must bear in mind that these figures cannot be taken without qualification, since, to a certain extent, they reflect the gradual increase in the immigration wave in the years following the war, reaching a peak in 1953. One is on safe ground if the specific evaluation is confined to patients who came to New York City in the last five years. During this period, the figures of total admissions of Puerto Ricans to Lincoln Hospital, (medical surgical and obstetrical cases included) were more or

Table 2. Number of Suicide Attempts of 64 Female and 16 Male Puerto Rican Cases, According to Number of Years of Residence in New York City

Time in N. Y. (Years)	0-7 years			Time in New York City						15-22 years		
	F.	M.	T.	Time in N. Y. (Years)	F.	M.	T.	Time in N. Y. (Years)	F.	M.	T.	
2-6 wks.	3	1	4	7-8	1	1	2	14-15	4	1	5	
1½-6 mos.	4	1	5	8-9	1	0	1	15-16	2	0	2	
6-12 mos.	1	0	1	9-10	2	2	4	16-17	0	0	0	
1-2	11	2	13	10-11	2	2	4	17-18	1	0	1	
2-3	1	1	2	11-12	4	0	4	18-19	1	0	1	
3-4	4	2	6	12-13	4	0	4	19-20	0	0	0	
4-5	4	2	6	13-14	0	1	1	20-21	1	0	1	
5-6	4	0	4					21-22	2	0	2	
6-7	7	0	7									
Totals			48				20				12	

\*At the date of writing.

less constant (55 per cent to 60 per cent of all admissions to the hospital).

Taking first those who were here the shortest time, one finds that four patients who were in New York only two to six weeks attempted suicide; five had been there about half a year, making a total of nine within about the first half-year after immigration. If one includes those who were there six to 12 months and one to two years after immigration, there are 14 more cases in the first two years (one more the first year, plus 13 more the second). Thus the total figure of suicide attempts between arrival and the end of the second year is 23.

Since there were only two cases in the third year and six each in the fourth and fifth years, it appears obvious that the most critical times are in the first two years, particularly the first six months after immigration. Thus, the figures indicate that a reciprocal relation exists between length of time after immigration and incidence of suicide attempts, with motivating problems more frequent or more intense in the beginning, and decreasing as the months and years go by.

The next question, therefore, concerned the nature of the emotional difficulties so frequently experienced by Puerto Rican immigrants and so persistently associated with "suicidal fits." Toward this end the precipitating events were explored in 69 Puerto Rican women and 14 Puerto Rican men. Of the women so questioned, 43 (62 per cent) gave, as the immediate cause of action, a fight with husband or lover. Fourteen girls (22 per cent), eight of them under 19, had quarreled with their parents, 12 women suffered emotional flare-ups mainly because of homesickness, or chronic illness or economic distress. The flare-ups in these instances would be triggered by news of sickness or death from the homeland, or by an eviction notice from the landlord, or by a disappointment with the welfare department.

Among the men, the precipitating causes were about the same: In 11 out of 14 (78 per cent), the immediate cause was a fight with wife or girlfriend or, in younger boys, a quarrel with the mother. Two men acted in fits of despair over losing their jobs, one after receiving an eviction notice for failure to pay the rent.

Significantly, in the overwhelming majority of cases, disturbances of interpersonal relationships within the family setting, either with the spouse or between parents and children, were re-

sponsible for the suicidal explosions. The statistics also show homesickness as a factor. Curiously enough, (and contrary to expectation) the economic situation appears to be a very minor contributing cause to these suicide attempts.

In examining the background of such emotional difficulties, one came to the realization that there are certain basic problems that every immigrant must face in the beginning. His emotional difficulties stem from two different sources. In the beginning, the immigrant is more upset by his emigration than by his immigration. Departure from one's homeland constitutes a far greater social and emotional upheaval than is usually recognized. The emigrant soon misses his old life; he longs for old friends, for the familiar faces of his neighbors. He remembers nostalgically the house he lived in since his childhood and yearns for the streets, the places and the countryside to which he is sentimentally attached. As one of the patients put it, "The fresh air, the sea and the beach was different in the Island, and here you live like in a box."

This experience of homesickness was greater in individuals who had enjoyed some social standing at home and were respected by friends and neighbors. It had been the basis of their pride and self-esteem. With their departure, these immigrants were denuded of their personal identity and, until they could again become a part of a new social group, they lived in a social vacuum—unhappy, insecure, and without a place in society. Small wonder they were irritable, depressed and discouraged.<sup>6</sup> This emigration hangover was a contributing factor in the increased suicide tendencies seen in the Lincoln Hospital patients in the first few months or years after immigration. In general, one knows that a sudden loss or change in a habitual life situation, whether social, economic or political, is considered a frequent cause of suicide. Strauss<sup>7</sup> described the high incidence of suicide in England by new arrivals there.

Once the initial emotional shock of emigration is over and the nostalgia subsides, the real problems of immigration gradually come more to the fore. As the immigrant grows accustomed to the social and economic systems of his new surroundings and is slowly absorbed by them, he adopts a new way of life and new cultural and social values that are often in conflict with the traditions of his past. He then, not only engages in a battle with his inner self, but even more so with close friends and relatives who

wish to remain faithful to the old ways. In the Puerto Rican population, this tug of war creates problems that have a particular effect on the tranquility of the family.

One case in point, out of many, is that of a 17-year-old girl who was brought to the hospital after attempting suicide. Her family was already broken up, her father having returned to Puerto Rico. The girl lived alone with her mother, who was deeply religious and kept her daughter under strict control. Having made some new friends, the lonely adolescent girl wanted to bring them home in the evening, as the other girls did. But her mother, adhering to family customs, would not hear of it, and this was the beginning of trouble. The girl was forced to meet her friends in the street and began staying out later and later in the evening, thus adding fuel to the mother's anxiety. When the girl stayed out very late, the mother would lock her out and she would spend the night with another girl.

Gradually, she took to frequenting the dance halls and hangouts in Greenwich Village, sharing a fascination with the place that her "gang" called "the Village kick." To offset the loneliness of her home life, she felt she had the right to live and enjoy life like other girls around her. She saw, in her mother's opposition, nothing but a total lack of understanding.

As a matter of fact, lack of understanding and guidance was her real problem. Her behavior notwithstanding, deep inside she was "decent" and still under the influence of her past upbringing. She never took an alcoholic beverage for fear of getting drunk. She rejected a boy who "had a crush on her" when she learned that "he took dope." She wanted to marry a man who would "pull me up, not down." Her plans for the future were well defined. She wanted to become a surgical nurse, get married and have children.

The girl attended church and confession regularly. With her strong need for a mother's love she was deeply distressed by the feud with her parent. In her search for peace, she had moved in with an aunt whom she considered to be more sympathetic. But this proved to be a mistake, because the aunt displayed the same punitive attitude as the mother. Now the girl had no one to turn to. She began to linger in church for hours or wander about, lonely and brooding, in the streets. Finally, she consulted a priest who tried to make her understand the anxiety felt by her mother and

aunt. However, her emotional turmoil was brought to a sudden head when her aunt, not suspecting the girl's inner anguish, threatened to punish her for being late by having the police deport her back to Puerto Rico and her father. It was at this point that the youngster attempted suicide.

Here, one sees exemplified the clash between the older and younger generations living in the shadow of two different cultural settings. While the patients anxiously cling to the family code, the children who are less rooted in the old traditions are attracted to the more liberal social customs of the new environment. Driven by fear of loneliness, and of social isolation as strangers, they are eager to become part of a social group in which they will be understood, appreciated and accepted as equals. Thus they become easy prey to primitive youth groups that afford them opportunities for emotional outlet and gratification.

In other words, the anxiety of the parents is in conflict with the anxiety of the children. However, it is not only in the clash between old and young that one can see the problems of adaptation. These problems also wield a disruptive effect on the husband-wife relationship. In a traditional Puerto Rican family, the man is master. The stability of the family structure is secured by the dominance of the husband as the provider, the wife's contribution consisting mainly in domestic matters.

The balance shifts in the new environment. Many women find it necessary to shoulder part of the burden of the breadwinner and go out to work. This sharing of economic responsibility with the husband not only diminishes his authority as head of the household, but also justifies the woman's claim for greater freedom and independence. At the same time, her absence from home during most of the day, and the consequent failure to have common family mealtimes, lessens the chance for communication between family members. Weakening the cohesiveness of the family group, this social change gives greater leeway to the centrifugal forces of the instinct. Among the usual complaints of the writer's female patients about their husbands were lack of responsibility and lack of support, infidelity, coming home late, alcoholism and physical violence.

The men, on the other hand, accused their wives of lack of personal response, unbearable nagging and scolding, irritability and unjustified jealousy. In many instances, the concept of married

life had lost its boundaries. The writer was often in doubt as to the marital status of his patients. Some women, living with men as their common-law wives, regarded themselves as single, while others, living illegally with lovers, presented themselves as married. In this state of confusion it is evident, as our statistics show, that the woman is the one who suffers most.<sup>8</sup>

To recapitulate, it is mainly the disintegration of the family structure during the period of adjustment that opens the Pandora's box to suicidal emotional disturbance, a disturbance that in the early stage of immigration is augmented and aggravated by the depressive emotional hangover connected with the emigration.

Specifically, in the case of the Puerto Rican family, the difficulty lies in the transition from the authoritarian system of the past to the more democratic form of family organization, which grants more freedom to the individual and entrusts the stability of the family unit to the sense of responsibility and moral strength of its individual members. Therefore, some education and guidance are sorely needed until the new values can be understood and the family can be integrated into the structural pattern of society as a whole.

In defining the causal connection between Puerto Rican immigration and suicide, it must be made clear that this causality is an indirect one. The immigration, with its sociocultural implications, gives rise to a basic psychic disturbance as a significant consequence of the process of disruption, adaptation and acculturation. Out of this emotional climate, a fertile atmosphere to aggravate suicide trends can develop. In this chain of reactions, the immigration situation represents the basic link, without which subsequent events such as family squabbles and other conflicts, either would not develop or would not reach the intensity of suicide attempts. To be sure, the constitutional nature and mental make-up of the individual always has to be considered as an important contributing factor.

Finally, on the question of whether there is a relation between the immigration-conditioned emotional illness and the pattern of suicide attempt, it is surprising to find that in all the cases reported here, there is one and the same suicide pattern, the "suicidal fit." Such a fit represents a conversion reaction in a nonpsychotic individual in an acute emotional state. Its uniformity in all the writer's cases seems highly significant, showing that there is a

definite relationship between the form of the illness and the suicide pattern. Consequently, one must assume that a difference in psychotic pathology reflects a difference in suicide procedure as a specific symptom of this pathology.

In reverse, one can assume that the pattern of suicide attempt is of some diagnostic value as to the underlying illness. This appears most obvious when one compares cases with psychotic conditions with cases of nonpsychotic background. If, for instance, a person in social distress suffers at the same time from a psychotic illness, such as melancholic depression, schizophrenic reaction, or an organic brain condition, the psychotic component necessarily, not only distorts the reaction to the social stress but modifies the mental functioning (and, therefore, the suicide procedure) and, what is most important, the inclination toward suicide. It is for this reason that psychotic cases were excluded from this study.

In the writer's opinion, the customary statistics on suicide, which do not differentiate diagnostic categories, are unspecific and misleading in their figures, being greatly influenced by the incidental percentage participation of the various diagnostic groups that are included. Diagnostic analysis of the basic illness and its causes in each individual case gives a far better understanding of the suicide action, and analysis of the suicide pattern goes a long way toward helping diagnose the underlying illness and its psychodynamics.<sup>10</sup>

#### SUMMARY

The emotional disturbance of Puerto Rican immigrants who attempted suicide has been studied and its relation to the immigration situation evaluated. It has been demonstrated that the interruption and subsequent disturbance of the individual's social and cultural stability causes personality conflicts and emotional illness, out of which an atmosphere favorable to suicide can develop.

One can clearly distinguish between two different immigration situations of a disturbing character. In the beginning, it is the sudden disruption of the familiar life situation and the social dislocation that cause a "hangover depression" after emigration; and, in the transition period of adapting, the change of social concepts and cultural values causes conflicts and disintegration of the

family, leading to unhappiness and tension with trends toward suicide.

The typical form of suicide attempt in all cases was the "suicidal fit," which is a conversion reaction in a nonpsychotic individual. It has been pointed out that a relationship exists between suicide pattern and basic illness, out of which the suicide crisis develops. The technical aspect of the suicide attempt and its outcome is modified by the environmental situation.

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## GASOLINE ADDICTION IN CHILDREN

BY JAMES J. LAWTON, JR., M.D. AND CARL P. MALMQUIST, M.D.

### INTRODUCTION

Symptoms of cerebral intoxication caused by gasoline fumes are a frequently discussed subject from the point of accidental inhalation in industry. The writers believe that intentional sniffing, as a manifestation of behavioral problems in children, is a neglected subject. In surveying the American literature, it was possible to find only a few sporadic case reports of intentional inhalation in the past 20 years.<sup>1-4</sup> Furthermore, there is no discussion offered in the standard textbooks of child psychiatry. This usually evokes great surprise from clinicians who refer to verbal reports. Three cases will be presented here of adolescents who appeared on the child psychiatry service of the University of Minnesota Hospitals\* within a two-month period with histories of so-called addiction to gasoline fumes. All three patients received individual psychotherapy, besides being exposed to intensive milieu therapy, which included daily school attendance and involvement in an occupational therapy program.

### CASE REPORTS

#### *Case 1*

This patient was a 15-year old boy, admitted to the child psychiatry service on referral from his local physician and the local welfare board. He had been in foster homes for four years, with a previous long-standing history of family maladjustment and emotional instability. In the foster homes, he had had difficulty adjusting and was also having school problems, academically and behavior-wise. Periods of depression with low self-esteem were interspersed with episodes of aggressive behavior during which he would provocatively engage in fights with his peers.

While in the hospital he appeared to be an unhappy boy who stated he had repeatedly run away from foster homes without really knowing why. He had resorted to the inhalation of gasoline fumes as a further means of escape. During these inhalation episodes, he said, he felt light-headed and had once had an "accidental period of unconsciousness." He had inhaled fumes two to five times a week over a six-month period, usually in the morning when warming up the family tractor at his foster home. Accompanying the gas inhalation, were visual hallucinations which he reported as "seeing jelly-like figures that were formless and flabby-shaped."

\*Minneapolis.

These figures would frequently scare him, and he would yell at them, telling them to let him alone. At other times, an erotic component was more prominent than hallucinations. There would be transient erections at the peak of his "drifting feeling."

The boy's physical and neurological examinations showed no pathology except a tremor on admission. An EEG was normal, as was the laboratory work. Psychological testing showed a WISC (Wechsler Intelligence Scale for Children) full-scale IQ of 96, but there was a 50-point spread between the performance scale IQ of 122 and the verbal scale IQ of 72; further testing did not indicate organic brain damage. Personality tests (MMPI, Rorschach, and TAT) were not interpreted as psychotic. During his subsequent two-month stay in the hospital and a three-month follow-up, there had been no recurrence of his hallucinatory symptoms nor had gasoline inhalation been resumed.

### *Case 2*

The patient in Case 2 was a 13-year-old delinquent boy on probation, referred by the Juvenile Court Service. He had a history of repetitive stealing and other acting-out in the community, along with enuresis. The family had been disrupted eight years previously when the mother obtained a divorce because of the father's repeated extramarital affairs. The boy had subsequently been raised by a hostilely-seductive mother and two sisters, ages 16 and 10, in a setting with a great deal of covert, and often overt, play of seduction between the mother and the patient; she would thus report with a great deal of mirth that it was impossible to stop him from grabbing her breasts all the time.

The boy said he had inhaled gasoline fumes at least once a week for at least two years. The inhalation was from gasoline cans or automobile gas tanks. He would begin inhaling by taking deep breaths of the fumes to the point of becoming dizzy with a "butterfly feeling" and would occasionally miss the "end-point" and "keel over." The inhalation made him feel as if he were "drifting in space" and as if he were "tingling all over." At these times he usually heard an "eerie" sound which he could only describe as a humming; this sound would often later increase in intensity for five to 10 minutes when he was breathing fresh air again. When gasoline fumes were not available, the boy inhaled carbon monoxide from the exhaust pipes of cars.

Physical and neurological examinations showed nothing abnormal; but the case was complicated by the history of a head injury the boy had suffered six months before hospital admission. He had been unconscious for about an hour. An EEG before this accident was normal, as was one obtained while on the hospital service. Laboratory work showed results within normal limits.

On psychological testing, a reverse spread in the WISC scales was noted, compared to Case 1, with a verbal scale IQ of 108 and a performance scale IQ of 86. The Bender-Gestalt indicated possible organicity. It was not determined if the psychological impairment was due to the head trauma or to his chronic gasoline addiction.

During his hospitalization, this boy was markedly hyperactive. He related to the nurses in a seductive manner, at times attempting to grab their breasts as he had done with his mother. He first began to respond to therapy with pride in not taking advantage of opportunities to steal. In respect to future gasoline inhalation, he said "I don't think I'll ever do it now, but sometimes I've told myself that before." There had been no recurrence of stealing or gas inhalation eight months after hospitalization.

### *Case 3*

This was the first hospitalization of a 12½-year-old girl who had first been admitted to the pediatric service. She was referred by her local physician because of complaints of "dizzy spells, eye difficulty, vague pains in the neck and back, and having queer sensations in her head." She was the only child of a 34-year-old-mother and a 43-year-old father. The marital situation was disturbed. The mother was an extremely domineering person, competitive and hostile toward men, who vowed never to have another child because of the "horrors" of childbirth. The father was a passive, ineffectual person, hospitalized six months before the girl's admission because of a serious drinking problem. He had never established a close relationship with either his wife or daughter and felt dominated by both of them.

In the hospital, it was revealed that the girl had been sniffing gasoline fumes from a large five-gallon can which was kept on the back porch of her home. She said she did this for the pleasurable sensations, and had been doing so for over two years about five times a week. She particularly wanted to sniff gasoline when she felt depressed, and experienced her greatest pleasure on reaching a point of giddiness. Two months before hospital admission, she had sniffed gasoline to the point of unconsciousness. Following this, her symptoms became much more intensified, with marked lethargy and withdrawal.

Physical and neurological examinations had essentially negative results. An electro-encephalogram following her first week in the hospital showed a moderately abnormal record, with slow waves and sharp waves focused in the left temporal lobe; but further clinical and laboratory findings were not confirmatory of any central nervous system damage. Blood study results, including blood chemistry, were within the normal range. Hemoglobin was 11.4 grams per cent. No basophilic stippling was seen on the blood smear.

Psychological tests, which included a WISC, the Bender-Gestalt, the Goodenough Draw-A-Man, the Rorschach, and the TAT, indicated the girl had a full-scale IQ of 120, with verbal and performance scales of 115 and 121 respectively. The Bender-Gestalt did not suggest central nervous system involvement. On the projective tests, the outstanding findings were preoccupation with mutilation and fascination by fire.

Two weeks after admission to the pediatric in-patient service, the girl was transferred to the child psychiatry service on suspicion that she had schizophrenic delusions. She expressed feelings that her head was not attached to her body, along with other feelings suggestive of depersonalization. During a three-month evaluation and treatment period, which included individual psychotherapy, she became more outgoing, manipulative, and seductive. Her depressed, reticent behavior changed in a sociopathic fashion, suggesting future psychopathy or a pseudoneurotic schizophrenic process.

After many interviews about her habituation to the inhalation of gasoline fumes, the girl still indicated a strong desire to inhale them. She further indicated that she could give no assurance of not doing so after leaving the hospital. She was somewhat evasive as to the reason, but indicated that the pleasure and gratification from inhalation were greater than the benefits of giving it up.

#### DISCUSSION

Gasoline is a mixture of hydrocarbons, mainly butane, hexane and pentane. According to Machle, poisoning by inhalation is much more rapid than by ingestion.<sup>5</sup> Susceptible people show symptoms after exposure to concentrations as low as 300 to 500 parts per million, and amounts in excess of 10,000 parts per million are rapidly fatal to most animals. Symptoms appear rapidly, and it has been mentioned that they are accentuated by a following exposure to open air.<sup>6</sup> Men in the petroleum industry with symptoms of industrial gasoline fume intoxication note that their symptoms become more severe on reaching open air. This is a paradox from two points which have not been adequately explained to date. It is not clear physiologically why this exaggeration of symptoms should take place solely from breathing fresh air, as the contrary would be expected. Possibly some other variable is needed to explain it, such as increased activity promoting circulation. Second, if the increased exposure to fresh air was believed *causally* related to the more pronounced symptoms, instead of merely being a *correlation*, the recommended treatment for severe

cases—with artificial respiration using mixtures of oxygen and carbon dioxide—would be a contradiction. At present, these problems have not been adequately resolved.

The most characteristic symptoms of acute gasoline intoxication are those involving the central nervous system. *Mild* symptoms are usually reported like those following in the case of a "naphtha jag": confusion, lack of self-control, excitement, combativeness, blurred vision and some in-co-ordination. These symptoms may be followed by depression and lethargy, headaches, roaring in the ears, trembling, staggering gait, nausea, burning in the chest or constriction in the throat. *Severe* cases may progress to dyspnea, cyanosis, delirium and coma; and epileptiform seizures and death have been reported within 10 minutes to four hours.<sup>7</sup> Meningismus may be present, and in nonfatal cases, convulsions can continue for days after the coma has passed and may be a sequelae.<sup>8</sup>

*Chronic* gasoline intoxication cases, which are rare, exhibit lassitude, muscular weakness, trembling, paresthesias, dizziness, loss of memory, speech disturbances, abdominal and limb pain, nausea and vomiting and either drowsiness or insomnia.<sup>9</sup> In the three cases presented here, hallucinations were a prominent clinical feature.

All three of the present patients came from disrupted family settings in which there was intense family strife. In two of these families the father was absent through divorce. The early childhood periods were characterized by much emotional upheaval and instability between the parents. The child was regarded at best with marked ambivalence, if not overtly rejected as another burden to complicate matters. The result was an unhappy child who sought narcissistic gratification which had not been forthcoming at earlier periods of life. There appeared to be severe oral deprivation. The children were observed to have an immense need for approval and acceptance, a need which was seen in aggressive, surly behavior—as a technique for getting affection or attention—or in an overcompliant, obsequious attitude to insure the few gratifications that were being received. A fluctuation between these two attitudes was usually noted. The particularly crushing nature of their environments appears chiefly responsible for bringing their conflicts so close to the surface that these chil-

dren are extremely sensitive to anxiety or to any other type of psychic pain. Thus, they feel the need for escape.

From a dynamic point of view it is believed that gas inhalation as a clinical entity is usually a manifestation of a character disorder, although it may be seen in psychotics or the mentally retarded. The patients involved show little ability to tolerate tension in respect to their drives, and have a great urgency for immediate gratification. They are thus primarily motivated by the pleasure principle. The main aim of their behavior is to seek constantly to rid themselves of their plaguing and all-pervasive tensions. Their persistent seeking for tension reduction by "taking in" gas fumes illustrates their basic oral character structure, and oral fixation would account for their low frustration tolerance with frequent aggressive outbursts, such as in fights, and for their adjustment problems in school and in the community. The oral deprivation would similarly account for the depressive features in these children, all of whom were basically unhappy and sad. It is believed that children who become addicted to gasoline fumes are attempting to obtain certain erotic gratifications, obtain feelings of security, and maintain their self-esteem simultaneously.<sup>10</sup> The relief of anxiety and narcissistic gratification achieved by inhaling the fumes is apparent in the cases presented, and the erotic component of transitory erections in Case 1 is significant.

The further contention is made that this group of children is in the group from which future drug addicts and alcoholics develop. Their emotional predisposition, which manifests itself in adolescence by seeking gratification from gasoline fumes, may later lead them to resort to similar techniques that are useful for the short-run alleviation of their anxieties and depressions; the ready availability of alcohol and drugs could provide the hoped-for immediate release from painful feelings.

#### SUMMARY

Three cases of addiction to the inhalation of gasoline fumes are presented with a discussion of the physiological and dynamic factors involved in such cases. It is believed that the statistical incidence of this behavior is much higher than commonly assumed, but no accurate figures are available because of the lack of an adequate investigation. Also, this behavior may not be revealed

in routine pediatric or psychiatric interviews. The predisposing factors in these children, which may lead to future reliance on alcohol or drugs, are discussed.

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## A PRELIMINARY STUDY OF HOSTILITY: THE HOSTILITY RATIO

BY RALPH H. ARCHER, M.D., M.S.

### INTRODUCTION

Anger is often avoided, seldom admitted, rarely praised and always present. What is the probability that it will be experienced by any one of  $n$  (number of) persons during a given time? Answering such a question would require us to have very basic knowledge indeed at our disposal—something like knowing the birth rate or the death rate. Right away it becomes apparent that this analogy is somewhat strained because an emotion like anger has an entirely different order of complexity than the more definite matter of being born or dying. Also, whereas the latter events occur only once, the business of experiencing emotion is a recurring phenomenon. However, simply because a phenomenon is repetitive is no valid reason why it cannot be counted and its frequency recorded.

It should be appreciated, for purposes of this study, that it is necessary to exclude an interest in who gets angry, in any attempt to analyze sources of anger, in situations which provoke anger, in how to deal with anger, and in whether anger has any usefulness or not.

In the literature, the subject of hostility is almost as much avoided as in everyday life. What studies are available tend to deal with the clinical aspects of hostility, including the role of hostility in therapy and therapeutic processes as well as theories regarding its origin. Attempts to measure it are nondirect. Administrative literature, although dealing frequently with authority and supervisory roles, painfully ignores the subject of hostility. There appears to be fairly common psychiatric agreement, however, that anger or hostility arises as a result of frustration or discomfort.

Some of the problems connected with the communication and recording of hostile events will be recognized as stemming from the fact that much frustration, discomfort and subsequent hostility remain unrecognized because of their unconscious nature, and are not reported or reportable. Other hostile events are, of course, denied. Then too, even though hostility may be consciously recognized by a respondent it may appear too threatening to be reported

or too insignificant. Whether such unreportable and unconscious experiences represent any constant value when dealing with large numbers of people cannot be definitely stated. However, it seems valid to consider the reportable part of the whole as reflective of the total incidence. It is necessary then, to keep in mind that one is dealing with conscious and reportable events only. The present concern will be with the frequency, or possible changes in frequency, of these events.

Perhaps the broadest general purpose of the project is to determine whether or not emotional events can be quantitated with any degree of consistency. If so, one can then examine a number of variables for their significance in affecting the frequency of an emotional event such as hostility. It would be far too presumptuous to describe this as an attempt to develop a tool or standard against which to measure administrative problems, changes or techniques, and their effects. It seems more reasonable to say that an attempt is being made to utilize or adapt a simple biostatistical method, which is widely known and understood, to accomplish the purpose.

The study is really concerned with two variables, one selected deliberately, the other incidentally. The former is the effect of the presence of an authority figure upon the ratio, and the latter is the sharp division between the clinical and nonclinical sample results.

It was originally intended to include a patient population sample in the study, but this aspect was abandoned in the interest of keeping the project relatively uncomplicated, as the basic nature of its philosophy seemed to require.

#### THE HOSTILITY RATIO

The hostility ratio is in effect a *weekly hostility incidence rate* which is the equivalent of the *average number of reported hostile incidents per 100 persons per week*. Although a frequency, it is not truly a rate. It is recognized that a respondent may experience more than one incident during the period of observation, although for reporting purposes no allowance has been made for multiple experiences.

As regards the population at risk, it is assumed that all persons in the samples have an equal exposure or chance of becoming

angry. The population at risk is considered to be equal to the number of persons reporting, with no purification of the denominator needed.

The ratio itself is composed of two parts, one objective and the other subjective. Experience dictates that objective material is more readily reportable than subjective material. In the case of the hostility ratio, it is considered that this may even be over-reported, whereas subjective material may be under-reported. Averaging the two parts represents an attempt to approximate a more realistic result.

A. Hostility-rate-O (objective)=hrO

$$\text{hrO} = \frac{\text{No. of reported objective hostile incidents per week}}{\text{No. of persons reporting}}$$

1. The number of *reported objective hostile incidents per week* is derived from the response to Question 2-A, Part I of the questionnaire (to follow).
2. In hrO, the respondent is an *observer* in the reported incidents.

B. Hostility-rate-S (subjective)=hrS

$$\text{hrS} = \frac{\text{No. of reported subjective hostile incidents per week}}{\text{No. of persons reporting}}$$

1. The number of *reported subjective hostile incidents per week* is derived from the response to Question 1, Part II of the questionnaire.
2. In hrS, the respondent is a *participant* in the reported incidents.

$$\text{The full hostility ratio}^* = \frac{\text{hrS} + \text{hrO}}{2} \times 100$$

$$\text{Example:**} \quad \text{hrS} = \frac{94}{397} \quad \text{hrO} = \frac{139}{397}$$

$$\text{Hostility Ratio (HR)} = \frac{\frac{94 + 139}{397}}{2} \times 100 = \frac{.5869}{2} \times 100 = .2935 \times 100$$

Hostility Ratio (HR)=29.4 incidents per 100 persons per week

\*Including both hrO and hrS.

\*\*Random figures are used, both for incidents (94 and 139) and for respondents (397).

#### COLLECTION OF DATA

Two state hospitals in Pennsylvania, Danville State Hospital and Clarks Summit State Hospital, were selected for the hostility study. Danville State Hospital cares for approximately 3,000 patients and has an over-all staff (medical and nonmedical) of 890

persons. Clarks Summit State Hospital cares for approximately 1,360 patients and has an over-all staff of 400. In both hospitals, the nursing department or service constitutes the largest single department.

Because of the almost infinite number of variables and test possibilities for studying hostility in various hospital employees, certain arbitrary selections were made. Thus at Danville State Hospital, a random population sample from the nursing department, consisting of 120 persons divided into groups of 20, received the questionnaire. At Clarks Summit State Hospital, 111 persons from the nursing department took the questionnaire. In no case, did a group exceed 27 in number, and no group contained less than 20 persons. The questionnaire was administered on all days of the week since this was one of the variables which it was felt should be checked for effect upon the reporting. The total sample of 120 persons from Danville and 111 from Clarks Summit may be considered "clinical." In this study, clinical is defined as persons who deal directly with patients and are in constant contact with them in the course of providing service. Such persons in addition to the nursing department are personnel from the recreation, occupational therapy, industrial therapy, and social service departments. A third sample, taken only from Clarks Summit, was of 97 persons who were considered "nonclinical" in that the service rendered to the hospital necessitated only indirect and intermittent contact with patients. Such personnel members were from such departments as laundry, dietary, maintenance, farm, accounting, and safety and security. Another major difference between the clinical and nonclinical samples is the size of the department and the proximity to department heads. It may be generally stated that, in the nonclinical services, the department heads are constant figures in relation to the personnel they supervise, whereas, in the nursing department, the department head is several supervisors removed from the lower echelon personnel. Since the influence of supervisory and authoritative personnel was one of the variables arbitrarily selected for testing, all the supervisory personnel were excluded from one sample, (Sample A) and were introduced purposely to determine the effect on reporting in another sample (Sample B).

## THE QUESTIONNAIRE

The questionnaire was hopefully designed to be self-administered by a group, with the person taking charge of the test present to answer questions if necessary. All answers were given in a classroom setting. An attempt was made to scale questions below the level of high school graduates so that they might be understood by the group with the least education. Many of the persons in the samples had completed only grade school.

It may be seen that no identifying information was requested. The questionnaire was divided into two parts: Part I, which was objective, and Part II, which was subjective. All questions in the final draft of the questionnaire were "closed."

It was anticipated at the beginning of the study that the objective rates would be consistently higher than the actual frequency and that the subjective rates would be lower. This constituted the rationale for combining the two rates and averaging them as a ratio.

There was a minimum of difficulty in administering the questionnaire. One of the interesting and common inquiries asked of the examiner was "Are patients people?" This was in connection with Question 1, Part I of the questionnaire.

The first draft of the questionnaire was felt to be, like the project itself, too ambitious in scope. Several questions were deleted from the second draft when it was determined from a pre-test situation that they did not figure significantly in the ratio. Although they constitute some of the natural history of the progress of the project, they are not included in this report.

Two characteristics of the questionnaire are fairly obvious and are considered worthy of emphasis. One is its simplicity, and the other is the straightforward and direct approach of the questions. It was felt that many persons are much more direct than they are frequently given credit for being, and that the disguised or indirect kind of question was unnecessary. Responses in the actual administration of the questionnaire seemed to bear out this belief. Also the simplicity of the questions was calculated to avert confusion as to what kind of emotional information was being collected.

Age .....  
Sex .....  
Time with Organization .....

1. Do you believe people get angry here at the hospital?  
yes ..... no .....

2. Have you seen other people get angry here at the hospital?  
yes ..... no .....

Was this:

A. During the past week? yes ..... no .....

B. During the past day (24 hrs.)? yes ..... no .....

1. Have you been angry, or felt angry or mad here at the hospital during the past week?

yes ..... no .....

2. Have you been angry, or felt angry or mad here at the hospital during the past day (24 hrs.)?

yes ..... no .....

A. If you were angry: (check one)

Did this start:

1. Before you came to work.....? 2. After you came to work.....?

1. When you were angry or mad, did you do anything about it?  
yes ..... no .....

Since the test was given in a classroom setting to small groups of individuals from a "captive" sample, it was not necessary to be concerned with the percentage of response to the questionnaire. It was 100 per cent.

There was no significant result obtained as regards the day-of-the-week variations, so that these have been excluded from the final tabulation.

Table 1 shows the results of the testing at Danville State Hospital. Sample A, with an  $n$  of 80, represents four groups of 20 each. Sample B, with an  $n$  of 40, represents the results from two groups of 20 each. The significant variable in Table 1 is the presence of the male supervisory authority figure in Sample B and the absence of an authority figure in Sample A. With the introduction of the authority figure into the test situation, the hostility ratio dropped from 50.6 to 28.8, a decrease of 21.8 in the mean of the reported hostile incidents per 100 persons per week.

Table 1.

Danville State Hospital	
Sample A	( <i>n</i> = 80)
hrS	= 0.40
hrO	= 0.64
HR	= 50.6
Sample B	( <i>n</i> = 40)
hrS	= 0.20
hrO	= 0.38
HR	= 28.8

## Symbols Used in the Tables

Sample A = Clinical personnel (supervisory authority figure absent).

Sample B = Clinical personnel with male supervisory authority figure present.

hrS = Subjective weekly rate of hostile incidents.

hrO = Objective weekly rate of hostile incidents.

HR = Hostility Ratio = Average mean number of hostile incidents per 100 persons per week.

Figures for hrS and hrO are rounded to second decimal, those for HR to first decimal after multiplication by 100.

In Table 2, which contains a similar Sample A and Sample B from Clarks Summit State Hospital, the introduction of the male supervisory authority figure caused a depression in the hostility ratio of 8.7 in the mean of reported hostile incidents per 100 persons per week. The results of Table 1 and Table 2 are not meant as any comparison of the two hospitals, but rather to show a consistent depression in the hostility ratio with the introduction of an authority figure. Although the authority figures occupied similar positions in their respective hospitals, their personalities,

Table 2.

Clarks Summit State Hospital	
Sample A	( <i>n</i> = 71)
hrS	= 0.45
hrO	= 0.60
HR	= 52.5
Sample B	( <i>n</i> = 40)
hrS	= 0.325
hrO	= 0.55
HR	= 43.8

## Symbols Used in the Tables

Sample A = Clinical personnel (supervisory authority figure absent).

Sample B = Clinical personnel with male supervisory authority figure present.

hrS = Subjective weekly rate of hostile incidents.

hrO = Objective weekly rate of hostile incidents.

HR = Hostility Ratio = Average mean number of hostile incidents per 100 persons per week.

Figures for hrS and hrO are rounded to second decimal, those for HR to first decimal after multiplication by 100.

appearances, and attitudes toward their supervisory roles were, of course, markedly different.

Table 3 which gives the combined results of the two hospitals, in an attempt to increase the number in the sample and de-emphasize the minor variations, shows a depression in the hostility ratio

Table 3.  
Combined Results of Both Hospitals

Sample A	(n = 151)
hrS =	0.425
hrO =	0.620
HR =	51.6
Sample B	(n = 80)
hrS =	0.263
hrO =	0.475
HR =	36.3

of 15.3 in the mean of reported hostile incidents per 100 persons per week. It should be noted that, although a depression occurred consistently in both components of the ratio, the greater changes were seen in the subjective rate. This, of course, would be anticipated by any reader who had had even average experience in interview situations.

Table 4, which is a one-hospital sample, reflects the unanticipated result with nonclinical personnel. It represents a nonclinical base line ratio without the introduction of any variable, but it may be seen that the ratio with the nonclinical groups was lower than for any of the clinical samples. Here is the sharp division, referred to previously, in that persons identified or defined as nonclinical gave only a mean of 24.3 reported hostile incidents per 100 persons per week, as compared with 51.6 incidents for 100 persons defined as clinical. This difference of 27.3 incidents per 100 persons per week is the greatest frequency deviation in the study. Its possible relation to authority structure will be considered in the discussion. There is no nonclinical sample from Danville State Hospital for comparison.

Table 4.  
Clarks Summit State Hospital  
Nonclinical Sample (n = 97)

hrS =	0.18
hrO =	0.30
HR =	24.3

Tables 5 and 6 represent the male-female relative frequencies in the two hospitals using the base line clinical samples. These are the clinical samples without the introduction of authority figures, shown in the tables under "Sample A." At Danville State Hospital the male personnel averaged 15.0 more incidents per

Table 5.  
Danville State Hospital  
(Excluding supervisory authority figure)

Male	( <i>n</i> = 40)
hrO	= 0.675
hrS	= 0.500
HR	= 58.8
Female	( <i>n</i> = 40)
hrO	= 0.575
hrS	= 0.300
HR	= 43.8

Table 6.  
Clarks Summit State Hospital  
(Excluding supervisory authority figure)

Male	( <i>n</i> = 30)
hrO	= 0.690
hrS	= 0.492
HR	= 59.1
Female	( <i>n</i> = 41)
hrO	= 0.553
hrS	= 0.438
HR	= 49.6

week per 100 persons than did the female personnel. At Clarks Summit State Hospital the male-female differential showed 9.5 more reported hostile incidents per 100 persons per week among the males than among the females. Although not included here as a table, the higher male incidence of reporting hostile events was also observed when authority figures were introduced into the test situation.

#### DISCUSSION

The crudeness and simplicity of this technique in attempting to understand something of the basic frequency of emotion must be admitted. An interesting although recognizably inaccurate way of looking at the results is in reference to the original question. What is the probability that anger will be experienced by any one of *n* (number of) persons during a given time? One might draw the conclusions that, if one is a clinical employee at Danville State

Hospital, his chances are one out of two, or 50 per cent, of becoming angry within a week if the supervisor is not present; and that if the supervisor is present, the chances are reduced roughly to one in four or 25 per cent. The fallacy of such reasoning is fairly obvious when one is able to make no statement as to what the hostility ratio actually means. Using this example, one is immediately faced with a problem of whether a lowered ratio in the presence of supervision indicates a decrease in anxiety, with greater comfort and less recognizable hostility, or whether the presence of authority only provides an inhibition of reporting hostility. Since the subjective rate suffers the greatest change when authority is introduced it would tend to indicate that more inhibition is present, rather than less hostility. This, of course, is far from conclusive. Another interesting speculation is whether or not the sample having the higher hostility ratio is more comfortable than the one with a decreased ratio. Of course any relationships here of comfort or anxiety to the presence or absence of supervision and authority are probably one and the same.

Any absolute or even relative benefits of a high or low ratio must, for the time being, remain speculative. There is the possibility that productive organizations, including hospitals, will have persistently high hostility ratios and that these may even be related to a high energy output. In this regard it is conceivable that a lethargic, disinterested staff might indeed report a low hostility ratio. On the other hand, it seems that most administrators would prefer fewer hostile incidents in the organization, with things running smoothly.

There are at least two elements, and possibly more, in connection with the authority figure which could be determined, to a greater degree of satisfaction, by future testing. These two are the relative values of authority in relation to its position in the administrative hierarchy, and the personality and attitude of the authority figure. As pointed out earlier, since the authority position was approximately the same in both hospitals in relation to the population sample tested, a suggestion is made that the personality structure, physical appearance and attitude of the person in authority are more significant than his position. No information has been obtained here in relation to female authority figures versus male authority figures.

Up to this point then, one can only state that authority does something to the numerical value of the hostility ratio. In this particular preliminary study, it consistently decreased the value. It is quite possible that the introduction of different authority figures might even increase the value.

It might be postulated that authority is involved in the differential between the clinical and nonclinical samples, and that this factor affected the low ratio of the nonclinical group, in at least two directions. One is that the personnel of the nonclinical sample came from small departments in which members experienced much closer and more consistent contact with the department heads than was the case with the clinical group. The other possibility is that the nonclinical workers, having only infrequent association with patients and less demand placed upon them for interpersonal service, had less hostility precipitated. Certainly there is a difference in the clinical and nonclinical personnel, as regards proximity to both supervision and patients. This area presents itself as a very definite future possibility for further work in connection with the incidence of hostility.

The writer mentioned earlier that one of the aspects of this preliminary study which was abandoned because too many questions were getting involved, was the relationship between the patients and the staff in a mental hospital. The question was originally posed as to what extent staff emotional patterns influence patient emotional patterns, or vice versa. The difference between the clinical and nonclinical results indicates that this also may be a fruitful lead to follow for future studies.

A word can be said here about the persistently higher male than female ratio in the clinical sample. Certainly this would not be an unexpected result in the general population, but it must be looked upon here with a certain amount of skepticism. After all, except for the medical staff, clinical work in a hospital is felt to be a basically female occupation, and many times the male members of the personnel are employed because of circumstances and not by their own choice. If a real male-female differential exists generally, it would seem that it ought to be determined by a cross-section of the general population covering many occupations. This male-female differential was the only significant one turning up among the relative frequencies checked by the present

questionnaire. In the matter of age and length of time spent with the organization no significant pattern was apparent, and the results of those tabulations are not included in the study.

Many more questions have been raised in the course of discussions about the study and there probably are many others which have not yet been thought of. It does not seem purposeful, in the absence of greater experience with this technique in a variety of situations, to include those which were raised, in this discussion.

The writer would finally like to mention that one of the inherent weaknesses in this concept of examining emotion is that only time and a continual effort to increase the number in the samples can establish a reliable base line (if indeed one exists) for emotional experience. One can hypothesize that, if such a basis exists, it is in the nature of a hostility ratio of 50.0. If such a hypothesis could be validated various statistical laws of probability could be applied to emotional events, making the significance of variables that much more reliable.

#### CONCLUSION

The hostility ratio was consistently depressed or decreased by the presence of a male authority figure. Differences in the amount of decrease suggest that this was due more to personality and attitude than to position in the administrative hierarchy. A subsequent study of positions is needed to clarify such an impression further. It is to be noted that female authority figures were not considered in relation to male authority figures.

The hostility ratio was significantly lower for nonclinical personnel than for clinical personnel employed in the same hospital. The possibility is seen that this may be due to less association with patients and hostile events, as well as to the factor of smaller department size and the proximity of these nonclinical employees to supervision.

A consistently present female-male differential is noted as a relative frequency of the ratio. The question is raised of whether this is due to male participation in a clinical, female type of occupation, or whether it may be the reflection of a real difference in the general population.

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## LOVE

Lovers are  
drenched with feeling  
raining to the tempo  
of the accelerating heart  
exhilarated by the exhalations  
of each other's breath  
that scents  
each muffled word  
of adoration  
with the pulsing  
tautness of the muscles  
which create caresses  
from the careless gestures  
that bring the craving  
closer to its meeting  
with time unborn  
whose presence is ushered in  
with utterances of devotion  
that erase the remembrance  
of fate now spent  
on yesterday's frustration.

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## EDITORIAL COMMENT

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### "NO ORIGINALITY OF PROPOSITION OR PROOF"

That amazingly apt self-appraisal of its own work, from the introduction to its "Final Report [to Congress] of the Joint Commission on Mental Illness and Health" will serve admirably as title for what this journal proposes to say in this first of a series of editorial comments on the unfortunate results of the commission's recent prolonged deliberations.\* The report discovers the same major problems in the psychiatric field that have been discussed in these columns for more than 10 years. THE QUARTERLY conceives it a duty now to point—by chapter and verse—to certain conclusions, assumptions, suggestions and proposals that the commission has brought forth, without "originality of proposition or proof," as proposed solutions for these vexing problems.

This journal's course is in response to a groundswell of strong objection to a number of the commission's proposals by the men all over the country who are in the forefront of the fight against "major mental illness"—held by the commission to be the core problem to be solved. It is intended here and now merely to review "realistically" some of the main objections to the commission's program and to deal incisively in future with successive segments of the proposition, refuting some of its more peculiar conclusions. The present danger, and a very bad thing indeed, is that the commission's mélange of recommendations may mislead Congress and state legislatures, delude citizen groups, and masquerade as "authority" for a while among workers in disciplines related to psychiatry. Organized psychiatry should see that it does not do so for long.

In some of its contentions, the report is simply a re-labelled American Psychiatric Association presidential address (vintage 1958). That address\*\* was discussed with considerable warmth in these pages.† The commission expresses full confidence in its

\*Action for Mental Health. The Final Report of the Joint Commission on Mental Illness and Health. xxxviii and 338 pages with seven appendices and index. Cloth. Basic Books. New York 1961. (This smoothly written and well-organized report in book form is reviewed briefly elsewhere in this issue.)

\*\*The American Psychiatric Association in relation to American psychiatry. *Am. J. Psychiat.*, 115:1, 1-9, July 1958.

†Editorial: Sticks and stones—and some names too. *PSYCHIAT. QUART.*, 33:1, 148-165, January 1959.

own competency when it suggests that "a comparable expert committee," be set up to continue its good work, but on reading the roster of members of the commission, it may be asked how many of them have had actual experience with major mental illness in a public mental hospital. Heading a university department, engaging in private practice, pursuing research, operating a small psychopathic hospital with selective admission policies, running a private sanatorium, serving a health department, or heading a children's service offers no such qualification. The book jacket presents warm endorsement by a social worker (a member of the commission), a person from the field of vocational rehabilitation and another from the field of public relations (a member of an advisory committee to the commission).

In the summary of recommendations, there is a section entitled "Image-Making." But nowhere in the book can one find any positive effort to build an image of faith in the state hospital, for the public, for patients, for relatives, for physicians, or for new medical graduates. Nonetheless, it is proposed that the state hospital, under another name, will continue to treat the seriously ill patient. There is "image-making" of another sort. One lurid account in the report describes conditions at Metropolitan (Mass.) State Hospital: "the foul air . . . the rotten chairs . . . the rags . . . just left to vegetate . . . they lie on the floor or they sit . . . most of them don't even have shoes to wear . . ." In another place: "Too many persons who are alcoholics, addicts, social misfits, or otherwise mentally ill themselves have been given mental hospital positions ranging all the way from attendant to superintendent."

"Image-making" has a good deal to do with recruitment—another section of the recommendations. Therein, it is *not* reported that professors of psychiatry generally (and others) do not direct prospective residents to state hospitals with good training programs. On the contrary, these men are diligently training their residents for the private practice of psychiatry, that is the office treatment of neurotics. Who will deny the negative effect on professional recruitment to the state hospital of the type of yellow journalism just exemplified by quotation, of academic eyebrow-lifting—and of just plain professional discrimination?

The section on recruitment is very slim. It is all very well as far as it goes; but recruitment is the main problem with which

the state mental hospitals are faced. Here there should be spelled out many concrete suggestions.

The commission's recommendation about hospital size is indeed a queer one. Maybe the notion came originally from the infant's ambivalence toward his monster parents; but through the centuries of groping which constitute the history of the human race, grown-up infants have promoted the suspicion that there is something intrinsically evil about great size. Pride in the biggest as the best has always been countered by the criticism, "too big!" The skyscraper, the Victorian British Empire, the television networks, New York City, the federal budget and today's automobile have all been attacked as evil on the grounds of size, whatever their demonstrable merits or demerits. Since some big things are demonstrably, objectively good, and some small things evil (consider pathogenic bacteria and Señor Castro's Cuba), this tendency to divide good and bad according to size is one of the most irrational of man's numerous irrationalities.

The commission recommends the breaking up of the larger mental institutions, a move that seems contrary to the trend in general medicine (although it is in striking agreement with the 1958 American Psychiatric Association presidential address). A non-technical but apparently soundly based report in *Fortune*\* emphasizes the trend toward the large general hospital and the large community medical center in general hospital practice. Massachusetts General Hospital is discussed, in what appears to be illustration, in a short article within the longer discussion. The *Fortune* article cites "anarchy" in present local hospital systems, noting an instance of an icy night in New York City with Harlem Hospital so overwhelmed with fracture cases that "the bones may go unset for three days," while in Columbia Presbyterian Hospital, "one of the nation's finest departments of orthopedic surgery" is idle because that hospital lacks an ambulance service. The article reports a suggestion by certain experts "that the 1,400 U. S. hospitals which have fewer than 100 beds be closed or converted into badly needed nursing homes." It should not be necessary to observe that *Fortune* does not advocate federal or state intervention to end general hospital "anarchy," and regards the job as one to be done

\*Guzzardi, Walter, Jr.: The public business. What the doctor can't order—but you can. *Fortune*, 64: 97-102, 163-166, August 1961.

—: Massachusetts General Hospital "an archipelago of excellence." *Op. cit.*, pp. 102-105.

by the profession and the communities concerned; but it is pertinent to note that the 100-bed limit—below which some experts would close general hospitals—is the figure at which the Joint Commission urges, in the recommendations under discussion, that general hospitals should provide psychiatric wards or departments. (Since the limit appears to have been set arbitrarily, maybe the Joint Commission's figure should be revised to 101.)

The *Fortune* article also might give rise to some additional pondering over the question of general relinquishment of mental hospital control to the communities. If community general hospital organization in the City of New York can be called "anarchy," even in a nontechnical but certainly friendly survey of the situation, one might well pause before hurling the mental institutions, too, into this sort of disorder. New York State has retained strict supervision of its community mental health program, and it is only fair to observe that the Joint Commission does not propose that communities be supplied with federal funds for the mentally ill and then allowed to do what they like with the money; in fact, it urges state co-ordination of local services. But the trend of the Joint Commission report appears to be in the direction of more and more local autonomy while the federal government pays an increasingly large share of the bills.

Oddly enough with further respect to hospital size, the Joint Commission report remarks in passing that Robert C. Hunt's Hudson River (N.Y.) State Hospital is "one of the most progressive large mental hospitals in the United States." In a later panel discussion of the published report, however, the commission's defenders skip lightly over highly pertinent comment on size by Francis J. O'Neill of Central Islip (N.Y.) State Hospital: "As far as I know, there has never been any scientific evaluation of the therapeutic potential of a mental hospital in relation to its size. No studies have been conducted to determine the optimum number of beds in terms of effectiveness of treatment.

"I now direct a large hospital: I have also directed a small hospital, and nothing in my experience would indicate that patients receive any better treatment or have any better chance of recovery in the small hospital because of its size alone. No one will deny that there are advantages in a small hospital and with increasing emphasis on community based care we will inevitably move in that direction. . . . But there are many factors unrelated to size which

may influence the effectiveness of the state hospital—its location in relation to the area served, public support, staffing pattern, budgetary consideration.”

Jack R. Ewalt of Boston (director of the nine-member staff—six of the nine by happy coincidence from Boston), who controlled the Joint Commission survey, replied to O'Neill with the contention that the large hospital “increases the distance between psychiatrist and patient.” To the uninformed reader, medical-staff-to-patient ratio—as O'Neill pointed out—would seem to be the factor determining the distance between psychiatrist and patient. It would be interesting to know if Ewalt would contend that a psychiatrist in an institution with a medical-staff-to-patient ratio of 3: 1,000 is closer to his patients than one in an institution with a ratio of 37: 3,200.\*

Is there not a sensible means of making existing big hospitals properly effective? Most were built (and filled) near large centers of population more than 30 years ago—long before active drugs were available. We can now subdivide them, we can tear down the fire-hazardous sections, and we can remodel other parts into suitable medical-surgical, geriatric, research, children's, adolescent or other services. With the new drugs, which were widely tested, reported upon, and ordered into general use in New York State in October 1954 (not 1955, which is the Joint Commission's date) hospital populations began to shrink. Soon primary trends should be definitely established, despite increased admissions (perhaps resulting from “case finding effect” from expanded community mental health services). The first of the modern small hospitals in New York State was planned in 1954 on the edge of a city within the orbit of a medical teaching center. Practical discussions of optimal sizes will be continued in future editorial comment in this journal.

The commission's recommendation about hospital size is indeed a queer one. The proposed prohibition against building any state hospital larger than exactly 1,000 beds appears to date back to the early 1920's, to the custodial era. It can be shown readily that a modern state hospital admits 60 patients a month to serve an average community. Contrary to shifting contentions in the Joint Commission report, the usual community clinic is primarily concerned with personality and psychoneurotic disorders. Only

\*Approximations of actual ratios in different states.

three of each 10 community clinic patients have been receiving treatment. It can be assumed that for actual mental illness the patient will certainly be sent on to the state hospital. To provide admission, children's, adolescents', research, medical-surgical, geriatric, and continued intensive treatment services, such a hospital cannot properly be scaled below 1,630 beds.\* To allow proper classification, there are minimal numbers of units for the admission service, the children's service, and the geriatric service in particular. Omission of any humane planning in the Joint Commission report for the large proportion of aged persons in our population with "major mental illness"—of another sort to be sure, than is the report's chief concern, a sort that the private practitioner rarely sees, or bothers to treat—is a glaring defect in the recommendations. Planning for the deranged aged, of course, has a great deal to do with the proper size of a hospital for the mentally ill.

To do effective clinical research (should senile and chronic psychiatric disorders be excluded automatically from all research as to causation and cure?) one has to have a population large enough to provide adequate matching samples for control, after excluding placebo reactors. The observation in the report that "clinical care, clinical teaching and clinical research move together and, indeed, are logically inseparable" applies particularly to the state hospital. "There is an equally great need," the report also observes, "for the development of research in service institutions. . . ." In another place, however, there is endorsement of the view that *formation of research policy* should be predominantly influenced by people trained in research as contrasted to the practitioners of medicine who control treatment institutions. Those who believe that major mental illness is a medical problem and that research and medicine grew up together, may question the orientation and motivation of the author of this section of the report. When he chides the state hospitals, where the only substantial testing of effective therapy for major mental illness has been performed—although "an extremely small proportion of the total research effort" is done there—one is troubled by the fact that financial support has been highly concentrated in a relatively small number

\*Minimal Hospital Requirements—Admission: 10 units, 300 beds; Research: four units, 100 beds; Children: six units, 90 beds; Adolescent: two units, 60 beds; Continued Intensive Treatment: 18 units, 540 beds; Medical-Surgical: 12 units, 360 beds; Geriatric: six units, 180 beds.

of major universities. Why? And why should we experiment with other forms of administration of the state hospital (suggested elsewhere) if major mental illness is a medical problem?

It is this journal's belief that some of the commission's propaganda against building to provide new hospital beds has misled state legislators and administrators in certain places to a degree that fire traps have not been replaced and suitable buildings—consonant with population needs—for the modern diagnosis and treatment of major mental illness have not been constructed.

A senseless juxtaposition of one heterogeneous group upon another—in the mixing of chronic psychiatric and chronic medical patients in chronic disease hospitals to be set up in the large evacuated mental institutions—is proposed by the Joint Commission. It is fair to note that there is one dissenting voice among the commission members, that of Miss Loula Dunn, who indicts the proposal in strong and uncompromising terms in an opinion printed as one of the report's appendices. Her indictment is based on the orthodox prohibition against the independent chronic disease general hospital.

The callousness of such a plan however can be readily seen in the certain anti-therapeutic effect of such a charnel house on both psychiatric and medical patients. The anticipated "great saving" in such a set-up would be achieved by a combination of the worst features of a state hospital infirmary service, nursing home and chronic disease hospital. To inflict this upon the mentally-clear bed-ridden patient with a terminal illness is a barbaric plan. To send a "chronic" mental patient to a custodial, second-class hospital half full of "physical incurables" is more barbaric. Who will say that there is no hope for this person as opposed to that one in this day of remission of chronic illness? Who will serve on the medical, nursing, occupational therapy or attendant staff of such a hospital? Who will face the patients' relatives in the matter of such "disposition"? There have been "receiving" state hospitals and "secondary" state hospitals in the dim past.\* Let us not resurrect them! We need to raise standards!

The Joint Commission report calls for presently inordinate numbers of psychiatrists for its proposed intensive treatment hos-

\*New York State had such a painful experience when Willard State Hospital was opened in 1869 for "chronic insane" patients, over the vigorous opposition of most members of the Association of Medical Superintendents of American Institutions for the Insane (now the American Psychiatric Association).

pitals, and there are other disquieting suggestions where personnel for these institutions is concerned. (The report indicates that in the custodial institutions professional personnel would be largely dispensed with, except in rehabilitation activities, and the ranks filled with asylum police or guards—perhaps the traditional force equipped with white coats and butterfly nets.)

There is a most dismaying proposal regarding psychiatric nurses. Rather than expand psychiatric training for the general duty nurse and rather than train psychiatric nurses for their specific tasks in nursing schools in psychiatric hospitals, the Joint Commission abandons the fight for the maintenance and improvement of psychiatric nursing as a ward service in close contact with patients. The report makes extensive use of Albee's work, *Mental Health Manpower Trends*,\* a survey undertaken for the Joint Commission.

Albee emitted a disheartening finding that the psychiatric nurse's job generally (New York State is still an exception) is, to quote the Joint Commission, "largely one of administration, teaching and supervising of attendants. Her role often is more akin to management than to caring for patients, except in helping the physician in the administration of therapy involving technological skills." In 1961, how a total of three graduate nurses, the customary staff of hospitals in certain places, can perform either the first or second function or both is a mystery.

The commission, apparently happy with this situation, suggests in effect the creation of a supernurse to undertake these tasks, a nurse not only with college training but with training on the graduate level as well: "This level of nursing duty, with its emphasis on teaching and supervision, is better served by graduate training beyond that encompassed either in the programs of hospital schools of nursing or in college nursing education programs..." Then the report observes, more than temperately: "... there is a serious shortage of nurses with such advanced training." This journal has expressed its opinion emphatically before on the increasing shortage of psychiatric nurses trained and able to work with mentally ill patients.\*\* It persists stubbornly in the

\*Albee, George W.: *Mental Health Manpower Trends*. Basic Books. New York. 1959.

\*\*Editorial: Knell? For a nursing service. *PSYCHIAT. QUART.*, 34:1, 150-152, January 1960.

opinion that more properly trained ward nurses, not more highly trained administrator-nurses, are what the mental hospitals need.

At a time when most of the patients are receiving drug therapy (and some are showing side effects), when interpersonal relationships on the ward are demanding special scrutiny and are used knowingly, when clinical research is on the upswing, when an effort is being made to orient public health nurses psychiatrically (as the Joint Commission notes), and when geriatric psychiatric patients are finally beginning to receive modern nursing care, the commission's comment on Albee's report takes one back to the state hospital of 1930. In truth—*THE QUARTERLY* thinks most experienced administrators would agree—the small model state hospital of 1,630 beds, already described, would require in addition to all other personnel, not a supervisory supernurse or two, but more than 150 nurses of various grades to give proper care to the acutely ill adult, the emotionally disturbed child or adolescent and the physically ill mental patient. They would be needed on the research service and even in the out-patient department. To maintain an adequate nursing service, such a hospital would need to graduate 30 nurses of its own each year in order to ensure their identifying with the hospital, and their proficiency. Incidentally, the commission report praises the early use of student nurses with chronic schizophrenic patients at Boston Psychopathic Hospital in 1952. The editor recalls such a use, dating back to 1929, at Utica State Hospital under Richard H. Hutchings.

Two other members besides Miss Dunn dissent from the commission report: Francis Braceland and Harvey J. Tompkins. This journal, too, cannot endorse the free-wheeling advice on the tax structure which they criticize in particular. In fact, *THE QUARTERLY* has previously criticized at length the making of too widely sweeping conclusions by another theoretical economist.\* Perhaps advice should be sought from practical government fiscal experts who know the realities: For one thing, the federal government has less money than the wealthiest state, which really cannot tax more easily than the poorest one. The mentally ill need much more money, but should it be raised further away from the taxpayer who has been shirking his duties? Should federal funds be reserved for educational and research purposes? Why does the commission propose (without explanation) to limit expenditures for

\*Editorial: One-track man. *PSYCHIAT. QUART. SUPPL.*, 32:330-342, Part 2, 1958.

these to 2½ per cent of service costs? Why is nothing said anywhere about the cost of supporting services in the discussion of hospital size?

A pious slip of the linotype on page 233 of the report is most appropriate to the fiscal discussion:

"The philosophy that the Federal government needs to develop and crystallize is that science and education are resources...like natural resources...and that they *desire* conservation through intelligent use and protection and adequate support—period." (The italics are THE QUARTERLY'S.)

Answers to the following will help this journal in future comments:

Do the commission members really subscribe to the view that "To Pinel's principles for the treatment of psychotics twentieth-century psychiatry can add little..."? In discussing treatment results in various places, were selective admission policies considered? Are the members sure that Gray was wrong when he maintained that patients with major mental illness were really physically ill? In what times and in what places were "The medical superintendents of mental hospitals...geographically, politically and philosophically isolated from the main body of the medical profession and from its humane and healing traditions"? Which commission members believe that the Schwartz "report" (pages 174 ff. of the Joint Commission report) describes a "typical" state hospital or "attendant culture" or accurately depicts aftercare services as generally in a primitive state of development? Which of the members believe that a veterans' hospital offers more than a state hospital in any respect? Does the Joint Commission accept the assertion that the actual work of planning and executing research now falls almost entirely to the nonpsychiatric disciplines? Or that, considering the successful use of phenothiazines in schizophrenia and of the antidepressants in manic-depressive disorders, there may not be "one direction" that promises *the* answer? Are the medical members comfortable in the proposed allocation of psychotherapy among the ancillary disciplines?

With Francis Braceland's other diffident dissent, this comment closes, for the present: "Had I been writing the report, I do not think I would have been quite as positive about some things..."

## LETTER TO THE EDITOR

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### CELIAC SYNDROME IN SCHIZOPHRENIA

To the Editor of the *PSYCHIATRIC QUARTERLY*:

Sir:

I note with considerable interest the article on "Celiac Syndrome in the Case Histories of Five Schizophrenics," by Harold Graff, M.D. and Allen Handford, M.D., from the Institute of the Pennsylvania Hospital in Philadelphia, published in *THE PSYCHIATRIC QUARTERLY*, Volume 35, April 1961, Page 306. This is an important contribution and I am particularly pleased to see emphasis on the importance of the celiac syndrome in the early childhood of schizophrenics.

I note, however, that on Page 312, the statement is made "A review of the literature reveals no previous report linking celiac syndrome and schizophrenia." Since I and my co-workers for many years have observed the frequent incidence of celiac syndrome in young schizophrenic patients, and have mentioned it in the literature, this statement should be corrected. The following references are offered:

1. Bender, L., and Hitchman, I. L.: A longitudinal study of ninety schizophrenic women. *J. N. M. D.*, 124:4, 337-345, 1956.
2. Bender, L.: Diagnostic and therapeutic aspects of childhood schizophrenia. In: *Mental Retardation. Proceedings of the First International Medical Conference*. P. W. Bowman and H. V. Mautner, medical editors. Pp. 453-468. Grune and Stratton. New York. 1960.
3. Bender, L.: The problem of organicity in schizophrenic children (functioning at a defective level). Read at the London Conference on Scientific Aspects of Mental Deficiency, London, England, July 1960. (In press.)

Lauretta Bender, M.D.  
Director of Research  
Children's Unit  
Creedmoor State Hospital  
Queens Village, N. Y.

## BOOK REVIEWS

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### **Adolescents: Psychoanalytic Approach to Problems and Therapy.**

SANDOR LORAND, M.D., and HENRY I. SCHNEER, M.D., editors. 378 pages with index. Cloth. Hoeber. New York. 1961. Price \$8.50.

The enormous, justified increase of interest in problems of adolescence inspired a series of lectures on this topic for residents in psychiatry at the State University of New York Medical School in Brooklyn. The lectures were also attended by psychiatrists, psychologists, child therapists and social workers. Nineteen psychoanalytic contributors presented 17 papers. Each is illustrated by one or more case reports, mostly drawn from the medical school division of child and adolescent psychiatry, which is directed by Schneer. As a result, the book is crammed full of psychoanalytic exposition ranging from the subjects of character formation and sexuality, through neurosis, delinquency and psychosis, to treatment of the patient and his environment.

The last two chapters deal with psychological tests, and present an anthropological essay on the adolescent in society. All the papers are readable and authoritative. The chapters on "The Suicidal Adolescent" and "Institutional Treatment" are based on papers published in this *QUARTERLY*. A few papers may be too complex for psychiatric residents, since the psychoanalytic formulations are rather sophisticated, but the book can be highly recommended to all psychoanalytically-oriented readers.

**A Rorschach Reader.** MURRAY H. SHERMAN, editor. 440 pages, including index. Cloth. International Universities Press. New York. 1961. Price \$7.50.

Practically all of the selected articles contained here have previously appeared in the various journals, and the more "serious" professional worker is probably familiar with most of their contents. This book, however, should certainly become required reading for students in Rorschach courses; the articles highlight the various approaches in the use and exploration of the Rorschach, and much of the material is basic and considered must-reading for any user of this technique.

**Faces in the Water.** By JANET FRAME. 254 pages. Cloth. Braziller. New York. 1961. Price \$4.00.

This is another of those books aiming to sensationalize mental hospitals, and produce horror in the reader. The author, a New Zealander, describes (partly autobiographically, as the bombastic blurb asserts) the reactions of a schizophrenic woman undergoing shock treatments. The reviewer thinks that such books should not be published—they serve no purpose.

**A Prelude to Medical History.** By Félix Martí-Ibáñez, M.D. xix and 253 pages including foreword and index. Cloth. MD Publications. New York. 1961. Price \$5.75.

**Henry E. Sigerist on the History of Medicine.** Félix Martí-Ibáñez, M.D., editor. xviii and 313 pages including index, foreword by JOHN F. FULTON, M.D., and introduction by the editor. Cloth. MD Publications. New York. 1960. Price \$6.75.

**Henry E. Sigerist on the Sociology of Medicine.** MILTON I. ROEMER, M.D., editor. xiii and 397 pages, including index, foreword by JAMES M. MACKINTOSH, M.D. and preface by the editor. Cloth. MD Publications. New York. 1960. Price \$6.75.

These three volumes belong on the shelf together, and the second and third, although in different colors, are in otherwise uniform format to make up a set. The three together represent two books of essays and short articles by Henry E. Sigerist, who was perhaps the greatest medical historian of all time, and one by Félix Martí-Ibáñez, one of Sigerist's most brilliant students and admirers. Martí-Ibáñez is also editor of one of the two volumes of Sigerist's work.

Martí-Ibáñez is a Spanish-born psychiatrist who is a historian, an educator, an editor, a speaker and a vivid writer. He sees medicine as more than a career—a tremendous adventure in the company of the great before a sweeping panorama of science and history—a view perhaps reflecting his own life of change and adventure willy-nilly. His prelude to medical history sweeps from the mist of paleolithic times to the day of space medicine. It is exciting intellectually and emotionally; it re-creates the color, the sounds, almost the taste, touch and smell of the lands and societies where medicine has been practised from the most remote times to the living present. He sees the figures of the past as "the good Hippocrates," "Clarissimus Galen," "Cardano, psychiatrist and gambler," "Weyer, savior of witches," "Haller, the great." He writes of "the code of Hammurabi," "the Greek miracle," "the patient as a saint," "the medieval town," the "watch under the stars: William Harvey and Galileo," "Mesmerism and homeopathy," "the WMA," and "atomic medicine; atomic pistols and atomic cocktails." He pictures the captive girl, Phyllis, making a horse out of Aristotle: Paracelsus getting drunk and defying the professors; and Hahnemann at 80 marrying a young woman and establishing a fashionable and active practice in Paris. In all this human wisdom and human folly is stuff to inspire the student and re-inspire the weary practitioner. It is also stuff to fire the lay reader with the wonder and the magic of medicine. The book includes a very useful chronology.

*Henry E. Sigerist on the History of Medicine* is a selection of works made by the author himself "some years ago" at the request of Martí-Ibáñez, and edited and arranged by the latter. Sigerist, great historian that he

was, never completed his projected eight-volume history of medicine, but his editor believes his "disciples" may some day assemble from his published short works a greater history than he himself would have been able to write, cramped by routine and discipline. In the present selection, he discusses such various subjects as "Paracelsus After Four Hundred Years," bedside manners during the Middle Ages, the history of American spas, his own knowledge at the age of 60 that he had "three incurable diseases," Paré's onion treatment of burns, and the social history of medicine. In addition to strictly medical matters, he contributes a discussion of roast turkey with truffles—and the lamentable lack of truffles in America; an autobiographical sketch on university education; a discussion of the spelling of personal names, with his own as illustration; and a short discourse on what the physician should read outside of professional literature—Sigerist favored the classics and standard works generally.

*Henry E. Sigerist on the Sociology of Medicine* is a collection of lectures and papers bearing on one of the most important (and most disputed) parts of his career, his advocacy of collectivism in medical practice. To Sigerist, personal health was part of public health and the concern of all, and medicine, the profession responsible for it, should, therefore, be regulated and supported by society as a whole. He favored compulsory governmental health insurance in the United States. He returned from a trip to Russia with "a conviction that Soviet medicine represents a form of health service adapted to the conditions of the industrial society of our day, and that what is happening now in the U.S.S.R. is the beginning of a new period in the history of medicine." Without prejudice to this view, however, he aimed to be an objective student of the physician and his social and professional position in all lands and all times. In days when medicine and medical people face so many and so rapidly changing professional, social and economic problems, the thoughtful physician, —regardless of his own or the author's economic theories—cannot afford to neglect Sigerist's penetrating studies of the economics and sociology of medicine.

**Outpatient Psychiatric Clinics.** And Other Mental Health Resources in the United States. 200 pages. Paper. National Association for Mental Health, Inc. New York. 1961. Price \$1.50.

This is a very valuable directory, listing public institutions throughout the country, state and national administrative offices, and public and private out-patient clinics, as of 1959. This is a well-printed, neatly-bound volume which should be of the greatest ready-reference use both to private practitioners and institutional administrators.

**The House of Healing.** By MARY RISLEY. 288 pages. Cloth. Doubleday. New York. 1961. Price \$4.50.

Mary Risley is said, on the flap of this book, to be "A woman of many interests—medicine and the theater being predominant." Her book is intended as a layman's history of the hospital, and she has evidently labored long and diligently at literary sources and "annual reports" (the implications as well as face value of which she dutifully accepts) in preparing material. The book seems to be directed toward laymen who, often without any preparation, are appointed to serve on the boards of voluntary hospitals which have no religious affiliations. One's enjoyment of the book is impaired as a consequence of inadequate attention to editorial work and there are examples of faulty proofreading such as "where as" for "whereas," and "orological" for "urological."

The impact of insurance plans is inadequately dealt with, and no hint is given of the influence of labor organizations in the health field. The author repeatedly urges a return to consideration of the patient as an individual but does not face up to the fact that the trend is altogether in the opposite direction and toward the introduction of automation in nursing care and the elimination of the small personally-oriented hospital. The fact of the enormous growth of the Catholic Hospital Association (and the reasons for this in places like the Protestant South) is not noticed, and no material on organizations such as the National Health Services, the U. S. Veterans Administration or the great state hospital systems is included.

**Your Child's Speech Problems.** By CHARLES VAN RIPER. 139 pages. Cloth. Harper. New York. 1961. Price \$3.00.

Charles Van Riper is an accomplished author and this book is both authoritative and well written. It covers all the common problems which arise in practice. Its definitions are accurate but understandable to the layman and the advice is sensible. A book to be recommended for the practising psychiatrist or for the hospital library, it will save a lot of time. The reviewer suggests: "Better buy two or three since you will never get it back from a borrower!"

**The Others.** By ANN AIKMAN. 185 pages. Cloth. Simon and Schuster. New York. 1960. Price \$3.50.

A well-written, melancholy, and at bottom meaningless novel concerns the vacation-encounter of two families which have nothing in common: Their heads are an unsuccessful, aging, modern architect, and a dissatisfied businessman. Everybody is dissatisfied; the younger generation is brainless.

**Einfuehrung in die Psychiatrie. (Introduction To Psychiatry.)** By

KURT KOLLE, Dr. med., Prof. of Psychiatry and Neurology at the University of Munich. 92 pages. Paper. Georg Thieme Verlag. Stuttgart. 1960. Price \$1.60.

As the outstanding representative clinical psychiatrist and academical teacher of psychiatry in Germany, Prof. Kolle does not require any further introduction in this country where his open-minded, unprejudiced and wide view of present-day psychiatry is respected and appreciated. Kolle's text, of which the reviewer translates the title as *Introduction to Psychiatry* is probably the most concise, most informative and, in addition, most readable of any introduction to a science which has taken on dimensions overlapping almost every biological and social science. It brings close to the reader the universality of psychiatry, but also brings the author close himself, as a wise physician and a man of courage and honest pursuit of his seasoned opinions. One wishes that this comprehensive introduction were translated into English.

**Psychosomatic Aspects of Paediatrics.** RONALD MACKEITH and JOSEPH

SANDLER, editors. 155 pages. Cloth. Pergamon Press. New York. 1961. Price \$8.50.

This is a symposium publication of a 1959 (May) meeting of the Society for Psychosomatic Research. As such it is not a comprehensive treatment of the subject but deals with certain specific topics, such as constipation and recurrent pains and some general themes, such as learning theory, theories of psychological development, the child and his symptoms, and identification. There is a report of an unstructured session in which Anna Freud tried to answer whatever questions were hurled at her. An index helps to make up for the lack of systematic arrangement.

**How to Live With Diabetes.** By HENRY DOLGER, M.D. Chief, Diabetes

Clinic, Mt. Sinai Hospital, and BERNARD SEEMAN. 192 pages, including index. Paper. Pyramid Books. New York. 1960. Price 50 cents.

This little book is an optimistic, non-alarming, sound, occasionally even wise, manual for all of those who are diabetic or are involved somehow in the welfare and care of diabetics. It is written almost from a psychosomatic viewpoint, and gives information on every aspect of the disease on a level which will be understood by the average intelligent layman. Even the expert physician will find stimulating notes deriving from the vast experience of the author, and he will find the book a valuable adjunct to his lessons of instruction to his patients.

**An Experimental Inquiry Into the Principles of Nutrition and the Digestive Process.** By JOHN R. YOUNG. With an introductory essay by William C. Rose. XXVI and 48 pages. No. 1 of "facsimile reprints" in the history of science, sponsored by the History of Science Society of the University of Illinois. University of Illinois Press. Urbana. Cloth. 1959. Price \$2.50.

This first volume of a new series in the history of science is a highly worthwhile endeavor to preserve and to make known the roots of medical science in a time when tradition and the achievements of our predecessors are losing appreciation and value. Young John R. Young submitted his much-too-long-forgotten and never adequately appreciated work in 1803 as an "Inaugural Dissertation, for the Degree of Doctor of Medicine, to the Provost Pro Tempore, Rev. John Andrews, D.D., The Trustees and Medical Professors of the University of Pennsylvania." The sound observation, the crystal-clear diction, the truly scientific way of deduction and presentation make this early work of a young medical genius, who died at the age of 22, a true classic of American medicine which should be made required reading for medical students. More than scientific skill and a brilliant mind can be found: a graciousness, respect and humility not found so easily and frequently in present-day presentations.

The editor and publisher deserve great credit for this unique offering. Printing and presentation are excellent and match the purpose.

**Aids To Psychiatry.** By W. S. DAWSON, M.A., D.M., F.R.C.P., F.R.A.-C.P., D.P.M. Eighth edition. E. W. ANDERSON, M.D., M.Sc., F.R.C.P., D.P.M., editor. VIII and 310 pages, including index. Cloth. Bailliere, Tindall and Cox. London. 1960. Price \$3.50.

The Students' Aids Series does not require any special introduction or recommendation. There is probably no English-speaking student of medicine, or physician, who is not familiar with one or the other or all of the series' concise pocketbook-type texts of medicine and pharmaceutics. After an interval of five years, a new, eighth edition of the volume on psychiatry is available. Its editor is well known in this country, Dr. E. W. Anderson, professor of psychiatry at the University of Manchester, England. The seasoned American psychiatrist will be very much interested in this up-to-date book, which gives a very good picture of, and insight into, the status of psychiatry in Great Britain. For the American undergraduate student, however, this volume will unfortunately have less value than most of the other volumes of the Students Aids Series, because of the differences in classification, social, administrative and legal aspects of psychiatry here and in Great Britain.

**The Intelligent Man's Guide to Science.** Two Vols. By ISAAC ASIMOV. xiv, vii and 853 pages, including indices, introduction, appendix, 210 illustrations and diagrams. Cloth. Basic Books. New York. 1960. Price \$15.00.

Isaac Asimov is a biochemist on the faculty of the Boston University Medical School. He is a scientist, a teacher, and a writer of scientific works, of popular science, and of no mean quality of science fiction. George W. Beadle, in the introduction to the present work, compares him, as a person who combines "extraordinary writing ability with wide knowledge and understanding of science," with Thomas Henry Huxley, who was so largely responsible for winning both scientific and popular acceptance of Darwinism.

Asimov writes both for the intelligent and educated layman and for the specialist in one science who wants an over-all view of the rest of science. His book is, thus, subject to criticism from specialists in all fields who would have reported on their own subjects differently, would have chosen different aspects to summarize, or would have surveyed their own specialties from different points of view.

This comment is, therefore, to say that while no one author in the modern world can achieve the Renaissance man's ideal of omniscience, Asimov has done an extraordinarily comprehensive and accurate job. Volume One covers, with historical background, the present state of the physical sciences, and Volume Two the biological sciences; and the subdivisions are by subject rather than the science concerned with it—those in the first volume ranging from the universe to the nuclear reactor, rather than from astronomy to nuclear physics; and those in the second, from the molecule to the mind, rather than from biology and biochemistry to psychiatry and psychology. The result is a clearer perspective than one could get by leaping from oceanography to metallurgy or from metabolism to organic evolution.

An appendix outlines briefly the mathematics on which scientific theory is based; and there is more in the discussion of feedback and thinking machines. There are both name and subject indices; and there is an excellent bibliography, mostly of works suitable for nonspecialist reading.

*The Intelligent Man's Guide to Science* (the present reviewer is unreasonably irritated by this title's possibly not unintentional echo of *The Intelligent Women's Guide to Socialism and Capitalism*) is worthy of a place in any general library, and should be of the greatest use in any library consulted by students of science.

**How Children Learn to Speak.** By M. M. LEWIS. 143 pages. Cloth. Basic Books. New York. 1959. Price \$3.00.

It would seem to this reviewer that any person associated with children, mothers in particular, would make the same observations that Lewis has pointed out and stressed in his book.

**Inside the John Birch Society.** By GENE GROVE. 160 pages. Paper. Gold Medal, Fawcett. Greenwich, Conn. 1961. Price 50 cents.

In the absence of generally available documentation, *Inside the John Birch Society* is an important book. It is not an "inside" book in the sense that it discloses what spies have discovered of a maleficent secret society; there is nothing so sensational; the "inside" is what is revealed by published documents and other similar material relating to the little-known workings of one of the most vicious political organizations to afflict this country since the days of the late Huey Long. The account of a New York City chapter session which must have been attended by somebody willing to talk out of meeting—or, indeed, by a spy for democracy—is included.

The society appears pledged to unquestioning obedience to its founder and head, Robert Welch, wealthy retired manufacturer, who seeks to impeach Chief Justice Earl Warren of the United States Supreme Court as a subversive, hates democracy, hates the United Nations, labels Eisenhower a Communist or Communist agent, charges that thousands of Protestant clergymen are Communists or fellow-travelers, opposes social security, and other "liberal" legislation, and has, as society-member bed-fellows, assorted anti-fluoridationists, anti-income-taxers, xenophobes, religious fanatics, anti-integrationists and anti-Semites. The best evidence that this book really reflects the "inside" of the "super-patriotic" John Birch organization is that much of it was printed in the *New York Post* before book publication and that no action for either civil or criminal libel has thus far come to this reviewer's attention.

**Van Gogh.** By W. H. AUDEN. 398 pages. Cloth. New York Graphic Society. Greenwich, Conn. 1961. Price \$10.00.

Van Gogh's self-portrait is presented in this volume by a selection of his letters. They are from the set of complete letters published in a three-volume edition three years ago and are designed to show the artist's work as a painter. Primarily dedicated to this purpose as this book is, its contents also throw a good deal of light on his tragic life and his mental disorder.

The letters range from notes to his brother "Theo" in a period when the young Van Gogh was displaying mental abnormality in the form of religious fanaticism, to uninhibited and "coarse" letters to fellow painters. Letters from the institutions where he was confined in his last years are of considerable psychological interest. He was in good enough contact, at least at the times of writing, to realize the fact of his own illness. There was some amelioration in that he was allowed to paint, but his picture of the French asylum in 1889 is a sketch which it is unfortunately not easy to forget.

**Projective Psychology.** By LAWRENCE E. ABT and LEOPOLD BELLAK. 485 pages plus index and illustrations. Paper. Grove. New York. 1959. Price \$2.95.

This is a paperbound reprint of the original Knopf publication. The book serves as an introduction to clinical methods in the assessment of personality and will certainly be of value for the beginning student in this area of work. It is a welcome addition to Grove Press' expanding list of Evergreen's worthwhile and outstanding books.

**Second Conference on Medical Mycology.** CHESTER W. EMMONS, conference chairman and consulting editor, with contributions from 48 authors. Annals of The New York Academy of Sciences. Volume 89, Art. 1. Pages 1-282. Paper. Published by the Academy. New York. 1960. Price \$3.50.

For the institutional psychiatrist, mycotic infections are of more than academic interest (immunity in ringworm infections is considered by Friedman and Derbes). There is a section on therapy.

**Personality Development and Adjustment in Adolescence.** By A. A. SCHNEIDERS, Ph.D. 473 pages including index. Cloth. Bruce Publishing Co. Milwaukee, Wis. 1960. Price \$5.75.

This is a complete revision of the 1951 volume, *Psychology of Adolescence*, written by a professor of psychology who is director of psychological services at Fordham University. The very useful bibliography of references and suggested readings includes over a thousand new books and articles published since the original edition. It is unfortunate that the book is much oversimplified, moralistic and sometimes banal, and falls short of the announced aim—to provide a "thoroughgoing interpretation of the conduct and personality of young people" necessary for "High School teachers, parents, students in Psychology and counselors of youth." Some of the author's misconceptions are surprising; one would have thought that Gilbert and Sullivan put a hilarious stop to the search to "Make the Punishment Fit the Crime," but Schneiders states that the child who slaps or pinches "can be punished effectively by use of physical means inducing the same experience of pain," etc. He also classifies alcoholism along with the "coke habit and other forms," as based on the physiological thirst drive, socially directed into peculiar and unwanted practices. The book is rather poorly organized, so that one finds the discussion on intelligence under the "sociology" section, rather than under "psychology." One would have expected more of this practised author and experienced clinician, especially as he is the father of seven children "who became adolescents."

**Guidance in Today's Schools.** By DONALD G. MORTENSEN and ALLEN M. SCHMULLER. viii and 436 pages. Cloth. Wiley. New York. 1959. Price \$5.75.

Case guidance is a responsibility of educators, psychologists, social leaders and parents. The need for a comprehensive view of the philosophy and functions of guidance is imperative. Drs. Donald D. Mortensen and Allen M. Schmuller in *Guidance in Today's Schools* make the point unequivocally that our democratic society underlines the worth of the individual and that much concern must be given to an organization of guidance that works in harmony with the individual. The book deals meaningfully and significantly with the background of guidance in the field of education, the developing personality of the individual in the home and the community, the guidance-oriented curriculum in the schools, and the giving of occupational information in counseling and guidance. The authors feel that there must be acceptance of each individual by his own self as well as by others. They feel rightly that there is need for the knowledge of social values in our technological society. It is their thesis that specialized guidance service will assist all pupils to make wise plans and choices, together with healthy adjustments. In conclusion, they feel that provision should be made for challenging the educational experiences of pupils through curriculum and instruction.

*Guidance in Today's Schools* is recommended as an introductory text in guidance, counseling and pupil personnel work. It is highly readable and sound, and is of considerable value to guidance counselors and school administrators.

**Human Decisions in Complex Systems.** WARREN S. McCULLOCH, editor, and 20 authors. 178 pages. Paper. New York Academy of Sciences. New York. 1961. Price \$3.50.

This monograph is likely to offer some rough going for the average readers of *THE PSYCHIATRIC QUARTERLY*. It consists of four parts: survey of the problems that must be solved in future systems (human decisions in missile systems and command control centers), theoretical approaches to the decision-making problem, empirical research evidence regarding decision making, and the reticular formations. In the past, conferences of this type have fallen between the two stools of not having sufficient facts to understand natural phenomena and not being able to bring adequate models into more than an analogous relationship with phenomena. The present volume is also plagued by the difficulty in bringing the material which was under discussion into profitable relationship with the practical problems which insist on emerging.

**The Integrative Action of the Nervous System.** By SIR CHARLES SHERRINGTON. 413 pages. Paper. Yale University Press. New Haven. 1961. Price \$1.95.

Yale University, which has held the copyrights on both the 1906 and 1947 editions of Sherrington's classic, here brings out a reasonably priced paperback edition of this frequently quoted and widely read book. Although Sherrington is not as much read today as two or three decades ago, there are few medical students who have not at least dipped into his pages. For anyone on the shady side of the half-century mark, turning these new pages of familiar phrases evokes a feeling of nostalgia mixed with depression. Here once again is the dedication to Ferrier—Ferrier, who, in the eighties, could let scarcely an issue of the *Journal of Physiology* go to press without crossing swords with Schafer. Here is the name of Graham-Brown (who, again in the eighties, was timidly deferring to Horsley and being brought up short by the same Schafer). One again smells the dust of the Series B volumes of the *Philosophical Transactions of the Royal Society* (try to find them in a library today!) and one is sorry to realize that Sherrington has taken a place with Jackson and will soon be only a generation away from Magendie and Claude Bernard—*sic semper!*

**Character Analysis.** By WILHELM REICH. Translated by THEODORE P. WOLFE. 516 pages. Paper. The Noonday Press. New York. 1961. Price \$2.75.

The numerous and voluminous productions of Wilhelm Reich are well-known to the readers of THE PSYCHIATRIC QUARTERLY. *Character Analysis* first appeared in book form in 1945 (Orgone Institute Press). It was called a second edition since it was based upon an earlier 1928 publication, evidently in a journal. The paperback in hand is therefore referred to as a third edition. It contains additional material, "The Emotional Plague," taken from a subsequent journal publication, and "The Expressive Language of Living," not previously published.

At the present time, when pressure upon psychiatry requires an operational approach which can be validated by practical results in depth, there is very little room for purely speculative material and none at all for the rehash of professionally-discredited speculation. There is not the slightest justification for the claim printed on the cover of the present book that, "It takes character analysis out of the realm of psychology and puts it on the firm basis of natural science, in the form of orgone biophysics." The use of the word "biophysics" in this connection can only be regarded as an egregious effort to prop up the peculiar contents by the theft of a respectable symbol.

**Heredo-Retinopathia Congenitalis.** By CARL HENRY ALSTROM and OLAF OLSON. 178 pages. Paper. Hereditas. Lund. 1957. Price not given.

This is an exhaustive study, in the Scandinavian genetic-statistical tradition of Torsten Sjögren, of a hereditary form of retinochoroiditis. This disorder begins as a congenital blindness or greatly impaired vision without changes in the fundus, and progresses to blindness in which the fundus shows alterations which are relatively uncharacteristic. Ordinarily, there are no other neurologic abnormalities. Cataract and keratoconus are frequent complications. No cases have been available for autopsy but the electroretinogram is very commonly negative. The disorder is considered to be inherited as a monohybrid, autosomal recessive.

**Auto-Erotism.** A Psychiatric Study of Onanism and Neurosis. By WILHELM STEKEL. Translated by JAMES S. VAN TESLAAR, M.D. 282 pages with glossary and index. Paper. Grove. New York. 1961. Price \$2.95.

Copyrighted in 1950 by Liveright, this book now appears in paper covers. The work, with a foreword written by Emil A. Gutheil, M. D., does not offer too much to today's psychiatrist, but it can be suggested as a general instructive book for people who are interested in this subject. The author stresses his point that everybody masturbates, and that the practice of masturbation does no harm, even in its extreme, by giving 22 illustrated cases—which are not completely followed. Dr. Stekel's book has been of help in the past in dealing with misconceptions that have grown up around the practice of masturbation.

**The Psychology of Abnormal Behavior.** Second edition. By B. KATZ and R. T. LEWIS. 677 pages including index. Cloth. Ronald. New York. 1961. Price \$7.50.

This is an easy-to-read, neatly arranged text for the beginning student in abnormal psychology. In their attempts "to meet the needs of the student," however, the authors tend to oversimplify much of the material and erroneous impressions are very likely to be gained. Certain gross inadequacies are apparent throughout the text; the treatment of defense mechanisms, for one instance, is not only inefficient but glaringly inaccurate.

**More For Doctors Only.** By VIC FREDRICKS. 192 pages. Cloth. Fell. New York. 1961. Price \$2.95.

*More For Doctors Only* is issued in memory of Dr. Francis Leo Golden who wrote the original book. It is, of course, for many more persons than doctors—members of the ancillary disciplines, for instance, and just plain members of the great fraternity of patients. Some of the jokes reported in this volume are, of course, of at least Napoleonic distillation but the general level of humor is high. The psychiatrist comes in for more than his fair share of it.

**Early Identification of Emotionally Handicapped Children in School.** By ELI M. BOWER. VIII and 120 pages. Cloth. Thomas. Springfield, Ill. 1960. Price \$5.50.

This book asks the question: Can the classroom teacher be helped to screen, in an economical and productive manner, those children who are developing marked or severe emotional problems? Dr. Bower's report of a six-year research study indicates that with rating scales and sociometric devices teachers can become more objective in their judgments.

Identification is but one facet of the problems facing schools in the education of emotionally handicapped children. When it is compared with the complexities of legal, financial, legislative and parental aspects involved in the problem, it is evident that bigger and better questions are still to come.

**Thoreau.** By HENRY SEIDEL CANBY. 508 pages with notes, bibliography and index. Paper. Beacon. Boston. 1958. Price \$2.75.

This is a paperback edition of a standard biography, first published in 1939, of one of the most interesting eccentrics in New England literary history—a man probably best known for a somewhat dramatic withdrawal from friends and social life to live on the shores of Walden Pond and write about nature. Canby traces most carefully the intellectual development of Thoreau and the conscious processes surrounding not only his withdrawal from family and friends to live alone and write, but his first fruitless love affair, in which Thoreau obviously only half-wished to succeed, and his later years-long devotion to an older woman, probably the wife of Emerson. The unconscious dynamics of schizoid behavior and attraction for a mother-figure are not discussed; but the material is in such careful and such well-authenticated detail as to warrant a place for this book in the library of anybody interested in character-study.

**Transvestism Today.** By EDWARD PODOLSKY and CARLSON WADE. 128 pages. Cloth. Epic Publishing Company. New York. 1960. Price \$7.00.

The price of this thin book and its caveat, "The sale of this book is strictly limited to members of the medical profession, psychoanalysts and students in the field of psychological or social studies," suggest that it is intended for a strictly uninformed audience. It certainly is written in language which will appeal to the man in the street.

Apparently only the first few pages are by Podolsky. The style of the remainder suggests that they might have originally been written for a pulp magazine for "males." The book contains an uncritical review of the better-known material on the subject and a number of photographs of notorious transvestites. Most of the rest of the book is concerned with historical accounts of transvestites and a few alleged "confessions."

**Frustration.** By NORMAN R. F. MAIER. 264 pages. Paper. Ann Arbor Paperbacks. The University of Michigan Press. Ann Arbor. 1961. Price \$1.95.

**Treatment of Emotional Problems in Office Practice.** By FRANK F. TALLMAN. 426 pages. Cloth. McGraw-Hill. New York. 1961. Price \$11.00.

These two books are intended for readers other than psychiatrists. Maier, a psychologist, is evidently writing for the clinical psychologist in private practice since he customarily uses the word client instead of patient. He has done some work with rats which indicates that punishment of the frustrated animal fails to bring about a solution of the animal's behavior problems and he extends this observation into a general treatise on management of frustration in people. Along the way he rediscovers what is now common knowledge (that Freud was fallible). For the young, inexperienced student in psychology, the book should be useful.

Tallman's book is also better as a practical guide for the neophyte (in this case the general practitioner who wishes some insight into psychodynamics) than for the specialist. The book is one of several developed at the Los Angeles division of the University of California in its Division of Postgraduate Medical Education and seems to be addressed to very unsophisticated readers. Some of the basic science material is uncritically selected, evidently garbled, irrelevant to the purpose of the work anyway, and should have been omitted.

Although the book is an intellectually unsatisfying enterprise, it must be recognized that it deals with important questions of some practical aspects of patient care. The reader may ask, "Why should physicians at this level of education be instructed to deal with psychiatric problems which they will never really understand?" The answer is, "Because patients with such problems come to them." To the next question, "Why not send the patients to a psychiatrist who can take care of them?" the answers are, "Because they won't go," "Because there are no psychiatrists in the area," "Because the psychiatrists in the area are too busy," or "Because the patients can't afford it." If the reader of this review has a good, short answer to these latter questions it is suggested that he write another book and send it to the publisher of this one. On second thought, he might send it directly to the Secretary of Health, Education and Welfare.

**Adolescent Rorschach Responses.** By L. B. AMES, R. W. METRAUX and R. N. WALKER. 313 pages including index. Cloth. Hoeber. New York. 1959. Price \$8.50.

This is a normative study showing the developmental trends of from 10 to 16 years. Although a work of this sort is bound to be somewhat limited, it is, nevertheless, a useful guide and should encourage further research in this area.

**Uncle Shelby's ABZ Book.** By SHEL SILVERSTEIN. Unpaged. Paper. Simon and Schuster. New York. 1961. Price \$1.50.

This is a sadistic cartoon collection, designed to help all of "Uncle Shelby's" "little friends get all the things in life that they so richly deserve." There is some incidental attention to making life miserable for father and mother. Uncle Shelby suggests activities which range from throwing eggs at the ceiling and pouring sugar in the gas tank to being eaten up by a tiger. There is some very keen insight in this little collection and some good fun in a sardonic sort of way.

Despite his personal unalterable opposition to censorship, this reviewer would warn all within hearing that this book should never, *never*, NEVER be allowed to fall into the hands of children; it could inspire activities ranging from theft to arson.

**Sisters and Brothers.** By JULIAN MOYNAHAN. 280 pages. Cloth. Random House. New York. 1960. Price \$3.95.

A good topic is spoiled by the novelist's lack of understanding. A young boy, living in a religious orphanage, tells fantastic lies. The psychological substructure seems of no interest to the author. He is content to let a sister exclaim: "Monkeys and bears/A country underground with steps leading down to it from the dormitory of a Catholic institution/That is a lie, and the product of a corrupted imagination."

**The Bath House.** By A. P. FARETRA. 80 pages. Cloth. Bruce Humphries, Inc. Boston. 1961. Price \$2.75.

This somewhat anal compilation appears to be a privately-printed attempt at a satire. The author apparently dislikes everybody from publishers to God. A high point is a "poem" in which Harvard and Boston each line up "ten thousand arses strong," backsides to the Charles River, and engage in a flatus contest across the water.

**Drum and Bugle.** By TERENCE FUGATE. 405 pages. Cloth. Simon and Schuster. New York. 1961. Price \$4.95.

An interminable novel is written about adolescents in a military school in the South. The hero "balks at the stupidity and conformism of the school," to quote the publisher. Why the latter considered that the topic was interesting enough to justify publishing the book is a mystery.

**The Roots of Fury.** By IRVING SHULMAN and PEGGY BRISTOL. 360 pages. Cloth. Doubleday. New York. 1961. Price \$4.95.

The author of such books as *The Amboy Dukes* and *Velvet Knife*, seems to feel the need to produce something "serious," and attempts the story of a female juvenile delinquent. His explanations (and those of some real or imagined psychiatrists) are rather simple.

**The Wish to Fall Ill; A Study in Psychoanalysis and Medicine.**

By KAREN STEPHEN. 238 pages. Paper. Cambridge University Press. New York. 1960. Price \$1.45.

This book was originally published in 1933. It is concerned mainly with the Freudian interpretation of the early development of the personality. The author discusses the oral and anal phases, pleasure and displeasure, the Oedipus complex, guilt and various defense mechanisms. There is no mention of any other psychological principles, and the use made of various psychotic manifestations and the author's interpretation of them show the date of the original writing. If the book was to be republished, it should have been brought up to date.

Nevertheless, for anyone interested in a popular account of the Freudian concept of the early development of personality, this book can be recommended.

There is no attempt either to prove or disprove the various theories promulgated. The author avoids as much as possible the use of specialized terminology. The descriptive language is excellent and the book becomes very readable.

**Memory for Designs Test: Revised General Manual.**

Perceptual and Motor Skills Monograph Supplement 2-VII. By FRANCES K. GRAHAM and BARBARA S. KENDALL. 188 pages. Paper. Southern Universities Press. Missoula, Montana. 1960. Price \$2.50.

A brief and easily administered clinical and research tool is described and evaluated in this manual. Orientation errors, tremors and perseveration in the immediate reproduction from memory of 15 simple geometric designs are attributed to "brain damage." The original standardization and validation procedures were reported in journal articles in 1946 and 1948, and the current work consolidates the material, with some additional studies presented. The MFD test has not been as widely utilized and accepted as the Bender-Gestalt. (The latter, eliminating the memory factor, and simply requiring copying of the designs, is therefore studying a "purer" function, while it is also an easier task, and can be used with younger and retarded subjects, thus widening the scope.) Research with the MFD is not clear as to how emotional and motivational disorders are reflected. This test, however, can be a useful addition to a tester's battery, and a quick check instrument for those who are working with organic problems.

**After Pentecost.** By RICHARD BANKOWSKY. 302 pages. Cloth. Random House. New York. 1961. Price \$4.95.

The author's first novel, *A Glass Rose*, received favorable reviews; unfortunately, he follows the usual routine of too early success; his second is boring, unreadable, and full of psychological holes.

**Psychology: An Introduction to the Study of Human Behavior.**

By HENRY CLAY LINDGREN and DONN BYRNE. 429 pages including index and illustrations. Cloth. Wiley. New York. 1961. Price \$6.50.

The first course in psychology is often experienced as a hodgepodge of the various areas of psychology; and, depending on his text and instructor, the student may well find himself disappointed, unstimulated and downright bored. Here is a text for the beginning psychology student that attempts to meet his needs and interests. The material is very well integrated and is presented in an unusually clear and interesting manner. Imaginative and uncommonly clever use of cartoons and illustrations to supplement the text contributes to the over-all appeal and originality of this particular book.

**Handbook of Aging and the Individual.** JAMES E. BIRREN, editor.

939 pages including index. Cloth. University of Chicago Press. Chicago. 1960. Price \$12.50.

This is the first of three reference works which are designed to summarize in an organized manner all knowledge that is presently available about human aging. This first volume is a huge one, specifically concerned with the biological and psychological bases of aging. Graduate students, professionals and research scientists who are in any way interested in this area will eagerly welcome the wealth of valuable material contained in this excellent, authoritative work.

**Essentials of Neurology.** By JOHN N. WALTON. VI and 422 pages. Lippincott. Philadelphia. 1961. Price \$6.75.

Walton has managed to get practically every neurologic entity and complaint into this small book, which employs British spelling and clinical terminology. It relies on a reasonably up-to-date basic background of anatomy, physiology and pathology. Its worst sins are the lack of emphasis upon commonplace disorders (as a result of including so many unusual items in a book of this size), and a thoroughly uninspired style.

**Principles of Dynamic Psychiatry.** Second edition. By JULES H. MASSERMAN, M.D. 322 pages including index. Cloth. Saunders. Philadelphia. 1961. Price \$8.00.

This second edition of Masserman will be welcomed as an introductory text. The author has incorporated the more recent contributions in psychiatry and its allied fields, and has included sections on ethology, information and systems theory, disturbances of communication and the evolution of psychotherapy. The whole work is extremely well organized, is clearly written and concise.

**Contemporary Theories and Systems in Psychology.** By BENJAMIN

B. WOLMAN. 613 pages, with bibliography and index. Cloth. Harper. New York. 1960. Price \$7.50.

This book contains a very readable and reasonably objective review of psychological theories. The larger part is devoted to those grouped in accordance with the principle of "common routes," which consist of theories oriented toward natural sciences that have been influenced mainly by nineteenth-century philosophers. The remaining parts deal with the principles of scientific method, and some crucial questions and answers which present the author's own philosophy in psychology. Priority is given to the logical order rather than to the chronological. The concepts of rebellious theories are discussed at considerable length, but there is an unfortunate omission here of Freud. The author seems objective, however, in discussing the concepts of the various theories he does present; and this book should be useful for teaching, for collateral reading, or for general orientation.

**The Analysis of Dreams.** By MEDARD BOSS, M.D. Translated by ARNOLD

J. POMERANS. 223 pages with references and index. Cloth. Philosophical Library. New York. 1958. Price \$6.00.

This book is an attempt to find a way to study the dream phenomenon itself, to examine its meaning for the present and future life of the dreamer by removing all the disguises and schemata of mental constructs of contemporary dream theories. Despite the author's insight into the vast realm of dreams, acquired through years of training in the classical Freudian school, the analysis of dream-life in this book is made through an unfamiliar approach, the phenomenological and existentialist. The material, which draws heavily on the writings of Binswanger and Heidegger, with the incorporation of the ultimate objective in Boss' own type of psychotherapeutic approach, may be stimulating to the reader.

**Psychoanalysis and American Literary Criticism.** By LOUIS FRAI-

BERG. 263 pages, including index. Cloth. Wayne State University Press. Detroit. 1960. Price \$5.95.

The author attempts to relate the use and value of psychoanalytic thinking to literary criticism. Selected writings of Freud, Jones, Sachs and Kris are reviewed and examined and certain noted literary critics are evaluated according to their knowledge of psychoanalytic principles and their application in their work. Professional persons in the field of psychiatry, especially those with literary interests, will undoubtedly be familiar with most of the material presented here. Students of literature will find much of value in this well-integrated and well-organized book that aims for a better understanding of creative works.

**Reflections on the Human Venture.** By HADLEY CANTRIL and CHARLES H. BUMSTEAD. 344 pages including index. Cloth. New York University Press. New York. 1960. Price \$6.50.

Through the writings of our great thinkers—philosophers, writers of poems, plays and novels, scientists, statemen and religious leaders—the authors have put together a book that explores the nature of human experience. Carefully organized, always highly readable, this book is warmly recommended to those people who are in any way concerned with the humanities and the sciences (psychology in particular), and with the finer appreciation of man's relationship to the world about him that results when these two bodies of knowledge become more interdependent.

**Psychotherapy With Schizophrenics: A Reappraisal.** JOSEPH G. DAWSON, Ph.D., HERBERT K. STONE, Ph.D., and NICHOLAS P. DELLIS, Ph.D., editors. 156 pages with index. Cloth. Louisiana State University Press. Baton Rouge. 1960. Price \$5.00.

**The Training of Psychotherapists: A Multidisciplinary Approach.** NICHOLAS P. DELLIS, Ph.D., and HERBERT K. STONE, Ph.D., editors. 195 pages with index. Cloth. Louisiana State University Press. Baton Rouge. 1960. Price \$5.00.

Although dealing with different subjects, these two books have much in common. Each is a collection of papers and discussions presented at symposia sponsored by the Department of Psychology of Louisiana State University and supported by grants from the United States Public Health Service. Two of the editors and five of the authors have contributed to both books. While obvious and worthy attempts have been made to eliminate bias between the medical and lay therapists, there is a strong undercurrent attempt to achieve equal status for lay therapy. When it comes to psychotherapy, one may quote Jimmy Durante: "Everybody wants to get into the act."

It should not be surprising that psychiatrists have an edge in the psychotherapy of schizophrenia; on the other hand, psychologists might be expected to have an edge in the field of teaching and learning. It is interesting that the outstanding contributions in both books are by the psychiatrist, Eugene B. Brody. In works like these, however, the individual contributor may not always be an appropriate or typical representative of his professional group.

The discussions are excellent in that they critically review the papers presented. Rogers' contribution to psychotherapy is disappointingly outdated. Malone's description of his own affective state with schizophrenics is highly suggestive of either therapeutic nihilism or defensive countertransference.

The book on training has a number of excellent theoretical and practical discussions. Yet, it also has many flaws. The function of the social worker as psychotherapist is thoroughly aired. Lief's ambivalence toward psychoanalysis (which is the cornerstone of theory in both books) is to be deplored. Most deplorable of all, is the scant reference to Ekstein and Wallerstein's *The Teaching and Learning of Psychotherapy*.

There is a great deal of unsubstantiated opinion in the books, but the discriminating reader may well find this instructive. Despite their flaws, both books are brief and well worth reading.

**Action for Mental Health.** By the Joint Commission on Mental Illness and Health. xxxviii and 338 pages with index and seven appendices. Cloth. Basic Books. New York. 1961. Price \$6.75.

This book is the final report to Congress of the Joint Commission on Mental Illness and Health. It is concise, candid and hard-hitting, in its presentation of facts (as the commission sees them) and proposals. The program proposed is certain to arouse discussion and heated debates; not all the recommendations will please or be accepted by many professional people. [EDITOR'S NOTE—Editorial comment expressing this journal's vigorous disagreement with many features of the report appears elsewhere in this issue of THE QUARTERLY.]

The report's impact is certain to be felt for years to come. It is "must" reading.

**Frauds.** By MICHAEL HASTINGS. 278 pages. Cloth. Orion Press. New York. 1961. Price \$3.95.

The reviewer found this to be a practically unreadable novel about an English soldier, returning from Cyprus to the sleazy environment of South London. The man is dissatisfied with everything. The characters are psychological caricatures.

**Handbook of Social Gerontology.** CLARK TIBBITTS, editor. 770 pages, including index. Cloth. University of Chicago Press. Chicago. 1960. Price \$10.00.

This is a basic volume which should find itself in the hands of all professional persons dealing with the psychological and social aspects of human aging. It is the second of three extremely important reference works that attempt to organize and summarize the field's existing body of knowledge. In this volume, 23 scientists and scholars in the field contribute 19 articles covering, "The Basis and Theory of Societal Aging," "The Impact of Aging on Individual Activities and Social Roles," and "Aging and the Reorganization of Society."

**No! In Thunder.** By LESLIE A. FIEDLER. 336 pages. Cloth. Beacon. Boston. 1960. Price \$5.00.

This is Mr. Fiedler's second collection of essays and is divided into four sections, each of which is provocative in its own way.

In Part I the author deals with practitioners of the fine arts. In the case of Dante, he discusses the development and use of the sestina as an art form. In his essay on Shakespeare, he stresses the paradox of illusion by dealing with a play within a play and the use of male and female parts for the opposite sexes. On Whitman, he discusses the development and changing of *Leaves of Grass*, with the advancing years of the poet. The Oedipus complex and homosexuality are the main themes in his discussion of Robert Louis Stevenson.

In Part II, Fiedler discusses the various "generations" of authors and their attitudes, beginning with the "twenties" and ending up with the angry young Britisher of the "fifties." Part III is devoted to the Negro and Jew in American society and the symbolism of the concept of boy and girl in our society. Part IV is a philosophical discussion of words and ideas. The writing throughout the book is of a high level. One may disagree with the author's ideas and beliefs, but one cannot help being stimulated by his presentation even though differing strongly with him. One who likes the essay form and who enjoys reading critiques will derive great pleasure from this book.

**Love and Death in the American Novel.** By LESLIE A. FIEDLER. 603 pages, including index. Cloth. Criterion. New York. 1960. Price \$8.50.

This is a huge and remarkable study of American literature. The author's framework is psychoanalytic, and although at times it seems more Fiedler-Freudian than Freudian, his never-ending interpretations and insights will at once outrage some and fascinate many who are interested in this area. Those who find themselves concerned, however, might compare this work with Legman's *Love and Death*, and wonder if many of Fiedler's revelations did not, in part, stem from this source. This reviewer feels that more than just a passing acknowledgment to Legman should be granted.

**Automatic Process Monitoring.** SIDNEY SIGGIA, conference editor. 11 authors. 114 pages. Paper. Annals of the New York Academy of Sciences. New York. 1961. Price \$4.50.

Everyone familiar with the principles of servomechanisms realizes to what an extent the techniques of automatic process monitoring are employed in industry, space travel, military installations, business and medical functions. In view of the amount of material available, a comprehensive treatment of the subject is almost impossible. About the only materials of interest to the medical reader in this collection, are a paper on oxygen monitoring and one on moisture.

**The General Hospital and Mental Patients.** By LOUIS E. DEMOLL.  
15 pages. Paper. University of Texas Printing Division. Austin. 1961.  
Price 20 cents.

This pamphlet is based on an earlier article written by Dr. George W. Jackson on the role of the general hospital in the care of mental patients. It gives some of the historical developments of the use of small units in general hospitals, the problems which occur in establishing them, the staffing necessary and some of their advantages. It can be recommended to general hospital administrators who are interested in developing psychiatric units, but because of its brevity and lack of specific information it has nothing new to offer to the psychiatrist familiar with administrative problems of either state or general hospitals.

**The Winter of Our Discontent.** By JOHN STEINBECK. 311 pages. Cloth. Viking. New York. 1961. Price \$4.50.

This book, states the author, "is about a large part of America today." When an author, who produced good work in years gone by, proclaims such a generality, one is willing to listen. What he has to say, however, is simply that whole sectors of otherwise "honest" people have a lax attitude toward the means by which they achieve success; the story has, as examples, a father and an adolescent son. What Steinbeck wants to convey, is not clear. Is it moral indignation? Is it resignation toward the atomic world? Whatever he wants, he does it badly.

**The Lime Twig.** By JOHN HAWKES. 175 pages. Cloth. New Directions. Norfolk, Conn. 1961. Price \$3.50.

The "intelligentsia" among writers and critics always have a literary hero whom nobody else understands and appreciates. In recent years, John Hawkes has had this distinction, as an "anti-realist" writer, who shows a "striking combination of detailed realism and over-all surrealism." In simple language, this means that the reader does not understand what it is all about. The background of this novel seems to be the stealing of a horse and racing him, under a false name. The characters are incomprehensible to this reviewer.

**The Jury is Still Out.** By IRVIN D. DAVIDSON and RICHARD GEHMAN.  
308 pages. Cloth. Harper. New York. 1959. Price \$4.50.

The authors report the trial of seven juveniles accused of murdering a 15-year-old boy, Michael Farmer. The account of the courtroom events is detailed and to a large measure successfully conveys the excitement of this sensational trial.

**Isabelle.** By JEAN FORTON. 192 pages. Cloth. Criterion. New York. 1960. Price \$3.95.

This French novel depicts without understanding, a schizoid, wealthy young man who seduces an adolescent girl. A reproduced French review hails this as a "remarkable novel." The reviewer thinks that if emptiness and psychological ignorance qualify for that title, the book is indeed "remarkable."

**The Negro in American Civilization.** By NATHANIEL WEYL. 360 pages. Cloth. Public Affairs Press. Washington. 1960. Price \$6.00.

This book gives a review of the history of slavery, which, although short, is excellent, then proceeds to deal with the opinions of various outstanding Americans on the question of slavery, especially Jefferson and Lincoln. The author brings out that most of these people, although in favor of freeing the slaves, were against their remaining in the United States, on the ground that they could not be assimilated. Although not stated definitely, there seems to be an implication throughout the book that it is impossible to assimilate Negroes in the United States. The author discusses intelligence, citing various so-called authorities to prove that the average intelligence of the Negro in this country is approximately 10 points below that of the white population.

He discusses the problem of morality and criminality, citing the higher incidence of crimes, especially of violence, among the Negro than in the white population, and gives this as an example of an inherent, inherited, unchanging characteristic. Although he mentions that in the South, criminality in the Negro, if confined to the Negro population, was seldom prosecuted, he fails to see the significance of this as a cause of wider criminality when the Negro moves into a desegregated area. He makes the claim that the Negro's behavior is inherent and cannot be changed; yet he contradicts himself by stating that the Negro in the British West Indies is well-behaved, although of the same background originally.

Although Weyl quotes numerous articles, there is no statistical proof for any of the statements he makes and he offers no constructive principles for attacking the problem. He paints a gloomy picture of a gradually spreading urban slum problem, as the number of Negroes in the larger northern cities increases. The implication in this book is that the only solution is the one offered long ago, that the Negro be removed from the United States to some other country. Such a negative approach is, of course, completely unrealistic and unnecessary. With every wave of immigration into the United States, social, moral and criminal problems arose. With each of these, a final solution or compromise occurred. This book is provocative. Certainly it is of value to any person interested in the welfare of this country, as it will provoke discussion and consideration of this problem.

**Proceedings of Two Conferences on Parapsychology and Pharmacology.** 40 authors. 86 pages. Cloth. Parapsychology Foundation. New York. 1961. Price \$3.00.

The conferences covered by this small book were sponsored by the Parapsychology Foundation and were held in November 1958 (Parapsychology and Psychedelics) and July 1959 (Parapsychology and Pharmacology). The meaning of the term "psychedelics" and the concern of the conferences are detectable in the following quotation from H. Osmond's contribution. "Some time ago I began to wonder whether there was some relationship between mediumistic and inspirational experiences...parapsychology and...experiences...with lysergic acid and mescaline. ... The substances that today produce measurable changes in perception were originally classified under rich names starting with hallucinogen, psychotomimetic, etc. We felt, however, that it would be well to coin a new name, ...

"After a discussion with Aldous Huxley, I felt that 'psychedelic,' which means 'mind manifestor' might fill the bill."

**Sensory Communication.** Contributions to the Symposium on Principles of Sensory Communication. WALTER A. ROSENBLITH, editor. 884 pages. Cloth. The M. I. T. Press. and John Wiley & Sons, Inc. Cambridge and New York. 1961. Price \$16.00.

This book is a product of a symposium on principles of sensory communication. The 38 papers are mixed in nature, some being reports of experimental material and some being theoretical formulations. The publishers express the hope that they may prove useful in formulating principles of sensory communication. Four papers deal with psychophysical or psychophysiological considerations, chiefly of a theoretical nature. Special senses are covered by 17 papers (olfaction and gustation, four; vision, seven; audition, six). Five papers deal with somatosensory function, three with cortical reception, one with adaptation. A good deal of the material is available in other sources (such as the *Handbook of Physiology*).

**Publication List.** By The New York Academy of Sciences. 54 pages. (Supplementary list, 4 pages.) Paper. New York Academy of Sciences. New York. 1960. Free.

This list, free for the asking, is well worth requesting and perusing. There are numerous articles which will appeal to every reader. Many of them have been reviewed in these pages of THE PSYCHIATRIC QUARTERLY, but there are others which will be found useful. The series which forms the Scientific Survey of Puerto Rico and the Virgin Islands is bound to arouse whatever latent naturalist's instinct may still linger in the subconscious of the Caribbean traveler.

**The Norristown Study.** By SIDNEY GOLDSTEIN. 366 pages. Cloth. University of Pennsylvania Press. Philadelphia. 1961. Price \$7.50.

In 1950 the University of Pennsylvania obtained a grant of \$100,000 from the Ford Foundation for the development of personnel and improvement of research in the behavioral sciences. A committee made up of psychologists, historians, social anthropologists and sociologists selected "Technological and Social Change in America with Reference to Problems of Human Adjustment" as the subject of a seminar in order to improve understanding of how people react to technological change and to uncover factors which have meaning in connection with social change. It was assumed that technological and social change have been too rapid for satisfactory human adjustment. The borough of Norristown, Pa., was selected as the region in which the significant variables were to be studied. The study was conducted on a course-credit basis and led to a number of graduate projects.

The backbone of the study rests upon material gained by a series of questionnaires. These provide a mass of data on things such as associations to which Norristown residents belong, or on what people say about how they are spending their time and so on, but no data which seem to this reviewer to have any bearing upon the validation of the assumption that technology has produced specific social ills or what these might be.

**Current Trends in Psychological Theory.** Fourteen authors. 229 pages. Cloth. University of Pittsburgh Press. Pittsburgh. 1961. Price \$6.00.

The present book is the tenth in a series entitled *Current Trends in Psychological Theory*. It contains the following material: "A Decade in Review" (Wayne Dennis, Brooklyn College), "A Decade of Social Psychology" (Dorwin Cartwright, University of Michigan); "Clinical Psychology: The Post-war Decade" (E. Lowell Kelly, University of Michigan); "The Flight from the Laboratory" (B. F. Skinner, Harvard); "Behavior as a Function of Certain Neurobiochemical Events" (Alan E. Fisher, University of Pittsburgh); "Heredity, Environment, Brain Biochemistry, and Learning" (Mark R. Rosenzweig, David Krech, and Edward L. Bennett, all of the University of California); "The Application of Physiology to Learning Theory" (Peter M. Milner, McGill); "Growth and Function of Mathematical Models for Learning" (William K. Estes, Indiana University); "The Simulation of Human Thought" (Allen Newell and Herbert A. Simon, both of the Carnegie Institute of Technology); "Problems in Problem-Solving Research" (Howard H. Kendler, New York University), and "Psychopathology and the Problem of Guilt, Confession, and Expiation" (O. Hobart Mowrer, University of Illinois).

## CONTRIBUTORS TO THIS ISSUE

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**RICHARD H. PHILLIPS, M.D.** Dr. Phillips, a diplomate of the American Board of Psychiatry and Neurology and a fellow of the American Psychiatric Association, has been teaching at the State University of New York, Upstate Medical Center since 1953. He is currently associate professor there. Born in Atlanta, he received his B.S. from the University of North Carolina and his medical degree from New York University. Following three years service in the United States Navy, he received his specialty training at Duke University. With primary interest in teaching and clinical research, he is now co-ordinator of undergraduate psychiatric training at the State University of New York. He is an associate editor of this *QUARTERLY*.

For several years, Dr. Phillips has been active as a preceptor in the resident-training program of the New York State Department of Mental Hygiene. The present paper has arisen out of his work in this capacity.

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**MUZAFFER ALKAN, M.D.** Dr. Alkan was born in Nizip Gaziantep, Turkey. She was graduated from the Medical School of Istanbul University in 1956, and completed a rotating internship in Fitkin Memorial Hospital, Neptune, N. J. Her residency training was at the University of North Carolina, Butner (N.C.) State Hospital and Willard (N.Y.) State Hospital. Following her psychiatric residency, she worked with children in the outpatient department of Grasslands Hospital in Valhalla, N. Y. In private life, Dr. Alkan is the wife of James M. Murphy, M.D., assistant director of Willard State Hospital and she is now living with her husband at Willard.

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**FRANK CoTUI, M.D.** Dr. CoTui, born in 1897, is a graduate of the College of Liberal Arts of the University of the Philippines in 1917. After receiving his medical degree in 1922 he served a residency and then served an internship at the Michael Reese Hospital in Chicago. He was assistant to the surgeon, A. A. Strauss, M.D., for three years; he was an instructor in pharmacology at New York University in 1930 and 1931; then was associate professor of experimental surgery and head of the surgical laboratories at New York University from 1931 to 1949. He was associate research scientist (biology), Creedmoor Institute for Psychobiologic Studies, Queens Village, N. Y., from 1950 to 1960. He returned to the Philippines in November of that year. Dr. CoTui has both taught and done research at New York University; he established the Bellevue Blood

Bank in 1947 and he has been active in medical aid to free China and to the Philippines. President Ramon Magsaysay commissioned him to survey the science needs of the Philippines in 1957. He is a member of Sigma Xi, the New York Academy of Medicine, the Gerontological Society, the American Society for the Advancement of Science, the New York Academy of Science and other professional organizations.

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WALTER BRINITZER, M.D. Dr. Brinitzer, born in Germany in 1910, received his medical degree, summa cum laude, at Kiel in 1935. He interned in Germany for a year, then went to British India where he was in private practice for nine years and served as a neuropsychiatrist in the British army medical corps for five. He was discharged with the rank of major. He came to the United States in 1949 and has been with Creedmoor (N.Y.) State Hospital since 1950. He is now a supervising psychiatrist.

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ALFONSO ORR, JR., M.A., M.S. Mr. Orr, a graduate of Georgia State College, has an M.A. from New York University and an M.S. from Fordham. He is an assistant research scientist in physiology at Creedmoor Institute for Psychobiologic Studies, Queens Village, N. Y. Mr. Orr did both high school and university teaching and worked as a medical technician before joining the Creedmoor staff. He is the co-author of a number of scientific papers. He has been studying for his Ph.D. in physiology at St. Johns University Graduate School of Arts and Sciences, where he has nearly completed the requirements.

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TOARU ISHIYAMA, Ph.D. Dr. Ishiyama received his Ph.D. in psychology from Western Reserve University, Cleveland, Ohio, and is at present director of the department of psychology, Cleveland (Ohio) State Hospital. He has been employed by the State of Ohio since 1952. He is also affiliated with Western Reserve University as a lecturer in psychology.

Dr. Ishiyama is married and the father of one child.

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WILLIAM L. GROVER, M.D. Dr. Grover is superintendent of Cleveland (Ohio) State Hospital. After receiving his M.D. from Ohio State University, he was associated with Columbus (Ohio) State Hospital until he was named superintendent of Cleveland State Hospital in 1954.

Dr. Grover is a member of numerous local, state and national medical associations. He was certified as a hospital administrator by the American Psychiatric Association in 1959.

Dr. Grover is married and the father of two boys and two girls.

**HILDE BRUCH, M.D.** As a pediatrician and children's psychiatrist, Dr. Bruch has been interested for many years in research in psychosomatic problems concerning obesity and anorexia, family interaction and parent education. She is clinical professor of psychiatry at the College of Physicians and Surgeons, Columbia University, and is acting psychiatrist at the New York State Psychiatric Institute and associate psychoanalyst at the Columbia University Psychoanalytic Clinic. Born in Germany, Dr. Bruch was graduated in medicine in 1929 from the University of Freiburg. She served a residency in Germany in pediatrics, then came to this country, where she served with the Phipps Psychiatric Clinic of the Johns Hopkins Hospital in Baltimore. She has been in the United States since that time.

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**BENJAMIN BLACKMAN, M.D.** Dr. Blackman, born in Chicago in 1925, received his bachelor's degree from Northwestern University in 1948 and his medical degree from Northwestern University Medical School in 1951. He interned at Michael Reese Hospital in Chicago, and served psychiatric residencies at Sheppard and Enoch Pratt Hospital and Spring Grove State Hospital, both in Maryland. He then held a fellowship in child psychiatry at the Institute for Juvenile Research in Chicago. He was certified in psychiatry by the American Board of Psychiatry and Neurology in 1958. He is now associate professor in the department of neurology and psychiatry at Northwestern University Medical School and is an assistant attending staff member at the Chicago Wesley Memorial Hospital department of neurology and psychiatry. He is a member of the American Psychiatric Association, the World Medical Association and other professional societies. He is the author of a number of scientific papers.

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**LAWRENCE BOOKBINDER, Ph.D.** Dr. Bookbinder was born in New York City in 1930. He received the degree of bachelor of electrical engineering in 1951 from Cooper Union, New York City, then served as an electronics engineer in the New York naval shipyard. He was in the army from 1953 to 1954. He received his M.S. degree from Northwestern in 1956. He served as a Veterans Administration clinical psychologist trainee from 1955 to 1958 in Veterans Administration installations in the Chicago area. His Ph.D. is from Northwestern in 1959. From 1959 to the present, he has been research clinical psychologist at the Ann Arbor Veterans Administration Hospital. He is the author of a number of scientific papers.

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**CHARLES WATKINS, M.D.** Dr. Watkins is professor of psychiatry and head of the department of psychiatry and neurology at Louisiana State University School of Medicine. Born in Mississippi, he took his pre-

medical training at Mississippi State College, and was graduated from the University of Tennessee Medical School in 1938.

Dr. Watkins began a residency in psychiatry at St. Lawrence (N.Y.) State Hospital in 1941. This was interrupted by service in the army from 1942 to 1946. Following military service, he completed his residency training at Duke University Medical School. He was certified in psychiatry by the American Board of Psychiatry and Neurology in 1948. Following his residency, Dr. Watkins moved to New Orleans where he received psychoanalytic training in the New Orleans Study Group. Since 1952, he has been on the full-time staff at Louisiana State University.

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**HENRY I. SCHNEER, M.D.** Dr. Schneer received his B.S. degree at Alfred University in 1937. After postgraduate biochemistry study at Maryland University, he went to the Long Island College of Medicine, from which he was graduated in March 1943. He had a rotating internship at Brooklyn Jewish Hospital, and, while in military service, he took the neuropsychiatry course at Columbia University. He became chief of the neuropsychiatric service at Camp Polk Station in 1945. Later he was resident in psychiatry at Manhattan (N.Y.) State Hospital and was certified in 1949, from the Columbia University Psychoanalytic Clinic for Training and Research. He served as assistant director of the New Rochelle Child Guidance Clinic and director of the New Rochelle Clinic's veterans' division.

In 1952, Dr. Schneer was director of Adelphi College Mental Health Center and professor in psychiatry of the Adelphi College Graduate Division. Now he is associate professor of psychiatry at the State University of New York College of Medicine, is on the faculty of its psychoanalytic division and is chief of the psychotherapy clinic in the psychoanalytic program. He supervises residents on the pre-adult service at Kings County Hospital. His previous publications appeared in the *Psychoanalytic Quarterly*, the *International Journal of Group Psychotherapy*, and *THE PSYCHIATRIC QUARTERLY SUPPLEMENT*.

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**PAUL KAY, M.D.** Dr. Kay is assistant professor of psychiatry at the State University of New York, Downstate Medical Center. He teaches in the division of child and adolescent psychiatry and supervises in the psychotherapy clinic in the division of psychoanalytic education.

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**MORRIS BROZOVSKY, M.D.** Dr. Brozovsky is instructor of psychiatry at the State University of New York, Downstate Medical Center. He is also assistant chief of service for child and adolescent psychiatry at Kings County Hospital.

W. DONALD ROSS, M.D. Dr. Ross is a graduate of the University of Manitoba, M.D. and B.Sc., (Med.) in 1938, a fellow, by examination, in medicine, of the Royal College of Physicians of Canada (1948) and is certified in neurology and psychiatry by the royal college and in psychiatry by the American Board of Psychiatry and Neurology. He had his internship and training in medicine at the Winnipeg General Hospital; in medicine, neurology and psychiatry at the Royal Victoria Hospital and the Verdun Protestant Hospital in Montreal; and in psychoanalysis at the Chicago Institute for Psychoanalysis, where he was graduated in 1958.

Dr. Ross is now associate professor of psychiatry and assistant professor of industrial medicine at the University of Cincinnati, and is attending psychiatrist and clinician in the out-patient department (psychiatry and medicine) and director of the psychosomatic service, Cincinnati General Hospital. He is consultant psychiatrist at the Veterans Administration Hospital, Cincinnati. He is a fellow of the American Psychiatric Association and the Society of Projective Techniques and a member of the American Medical Association, the American Psychosomatic Society, the American Group Psychotherapy Association, the American Sociological Association, the American Association for the Advancement of Science, and Sigma Xi.

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ARIK BRISSENDEN, M.D. Dr. Brissenden is assistant professor of psychiatry at the University of Cincinnati, attending psychiatrist at the Cincinnati General Hospital, assistant chief of the psychiatric service at the Veterans Administration Hospital, Cincinnati, and psychiatric consultant at Dunham Hospital, Cincinnati. He received his medical degree from the College of Physicians and Surgeons, Columbia University, in 1949 and is certified in psychiatry by the American Board of Psychiatry and Neurology. He is co-ordinator of the group psychotherapy program of the department of psychiatry at the University of Cincinnati. He is a member of the American Psychiatric Association and the American Group Psychotherapy Association.

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DAVID P. AUSUBEL, M.D. Dr. Ausubel was educated at the University of Pennsylvania (B.A. in psychology, 1939), Columbia University (M.A., 1940, Ph.D., in psychology, 1950) and Brandeis University (M.D., 1943). After receiving his M.D. and serving a rotating internship at Gouverneur Hospital, New York City, he was senior assistant surgeon for two years in the United States Public Health Service. He completed psychiatric residencies at the United States Public Health Service Hospital, Lexington, Ky. (1946-47), and at Buffalo (N.Y.) State Hospital (1947-48), and from 1948-1950 he was a psychiatrist at the Yeshiva University Psychological Clinic.

Since 1950, Dr. Ausubel has been professor of educational psychology at the University of Illinois. His books include *Ego Development and the Personality Disorders* (1952), *Theory and Problems of Adolescent Development* (1954), *Theory and Problems of Child Development* (1958), and *Drug Addiction: Physiological, Psychological and Sociological Aspects* (1958). He has previously contributed articles to THE PSYCHIATRIC QUARTERLY on the psychopathology and treatment of drug addiction (1948), on a psychopathological classification of schizophrenia (1949), and on the nature and diagnosis of neurotic anxiety (1956).

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JORDAN M. SCHER, M.D. Dr. Scher is assistant professor in the department of neurology and psychiatry at Northwestern University, is consultant at the sheriff's office at the Cook County (Ill.) Jail and holds other consultant positions in the Chicago area. He is editor of the *Journal of Existential Psychiatry*. Dr. Scher received his medical degree from the University of Maryland in 1949. He served in the navy, was a fellow in cardiovascular research at the Cleveland Clinic and directed research in primary atypical pneumonia at the Armed Forces Institute of Pathology. He served a psychiatric residency at the Psychiatric Institute of the University of Maryland and later was project director at the National Institute of Mental Health. He is co-editor of the book, *Chronic Schizophrenia*, published in 1960, has published numerous scientific papers and has been active in various professional groups and societies. He is a member of the American Psychiatric Association, the American Academy of Neurology, the American Academy of Psychosomatic Medicine, the American Group Psychotherapy Association and numerous other professional organizations.

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EDGAR C. TRAUTMAN, M.D. Dr. Trautman was graduated from the University Medical School in Munich in 1921, and served residencies at the Munich University Hospital and various psychiatric hospitals in Germany. From 1924 to 1929, he was at the University Institute of Neurology and the Neuro-Psychiatric Clinic in Frankfurt. He practised neurology and psychiatry in Frankfurt until 1937. He came to this country and received a medical license in New York in 1938. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology. He is now in private practice in New York City, where he has held a number of hospital appointments, including service at the psychiatric clinic, Mount Sinai Hospital. Since 1956, he has been attending psychiatrist and chief of the neuro-psychiatric consultant service, Lincoln Hospital, New York City. He is a fellow of the American Psychiatric Association and a member of other professional organizations.

**JAMES J. LAWTON, JR., M.D.** Dr. Lawton has been assistant professor of child psychiatry and pediatrics at the University of Minnesota Medical School since July 1958. He graduated from the Long Island College of Medicine in 1942 and was a resident in internal medicine at King's County Hospital, Brooklyn in 1943. Following the war, he was attending cardiologist at Meadowbrook Hospital, Hempstead, N. Y. during 1947 and 1948. His psychiatric training began at Brooklyn State Hospital where he served as senior psychiatrist and supervising psychiatrist from 1949 to 1955. He was trained in child psychiatry at the Institute of the Pennsylvania Hospital, and is certified in psychiatry and qualified in the subspecialty of child psychiatry. From 1950 to 1953 he was also a member of the executive committee of the American Group Therapy Association.

From 1950 to 1955 Dr. Lawton was associated with the American Institute of Psychoanalysis, where he lectured in 1954 and 1955. He has been a visiting lecturer at Teacher's College, Columbia University, and clinical assistant professor at the Downstate Medical Center of the State University of New York.

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**CARL P. MALMQUIST, M.D.** Dr. Malmquist received his M.D. from the University of Minnesota in 1958. Following an internship at Minneapolis General Hospital, he began his psychiatric training at the University of Minnesota Hospitals, where he is now a resident in psychiatry.

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**RALPH ARCHER, M.D.** Dr. Archer, born in Titusville, Pa., received both his B.S. and M.D. degrees from the University of Cincinnati. He holds a master's degree in administrative medicine from Columbia University. He has served as clinical director at Mayview State Hospital in Pennsylvania and as superintendent of Clarks Summit (Pa.) State Hospital. He is now director, county hospital services, Division of Mental Hygiene, State of Wisconsin. He served in the air force in World War II and holds a reserve commission in the United States Public Health Service. He is married and has four children.

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**JOSEPH ROBERT COWEN, M.D.** Dr. Cowen is the author of much poetry, some of it printed previously in this journal, as well as of numerous scientific articles. Born in Washington in 1923, he received his medical degree from the University of Maryland in 1950. He served an internship at the Wayne County General Hospital and Infirmary and served a residency in psychiatry at Spring Grove and at the Sheppard and Enoch Pratt Hospital, Baltimore. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology. He is now in private psychiatric practice in Baltimore.

*ERRATUM*

HAROLD GRAFF, M. D. Dr. Graff is the co-author of a paper, "Celiac Syndrome in the Case Histories of Five Schizophrenics," by Harold Graff, M.D., and Allen Handford, M.D., in the April 1961 issue of *THE PSYCHIATRIC QUARTERLY*, pages 306 to 313. His biography was omitted from the April *QUARTERLY* through an unfortunate mix-up in making up that issue. It follows:

Dr. Graff is a fellow of the Institute of Neurologic Sciences of the University of Pennsylvania and a resident in psychiatry at the Institute of the Pennsylvania Hospital, Philadelphia. Brought up in Bradford, Pa., he secured both his undergraduate and his medical training at the University of Pennsylvania, where he received his doctor's degree in 1958. He interned at the Philadelphia General Hospital. Dr. Graff is interested in the anatomic, psychologic and psychiatric aspects of feeding behavior.

## NEWS NOTES

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### CARL GUSTAV JUNG, M.D., DIES AT 85

Dr. Carl Gustav Jung, founder of one of the great schools of modern psychotherapy and generally considered one of the architects of today's psychiatry, died on June 6, 1961 at his home in a suburb of Zurich at the age of 85.

Jung, an early associate of Sigmund Freud, parted from him in 1913 after six years of collaboration, in a break which concerned, among other things, the nature of the libido. He then founded his own school of psychotherapy, known as analytical psychology, and taught and treated patients for over 45 years at Zurich.

Jung was born in a village on Lake Constance on July 26, 1875. He was the son of a minister, and religious faith is considered to be one of the principles on which he founded his system of psychotherapy. His differences with Freud occasioned a scientific and more general controversy which lasted for a quarter of a century. Jung developed a school which has long been completely independent of Freudian psychoanalysis. He again became a controversial figure during the 1930's and in World War II when he co-edited a German journal of psychoanalysis under the Nazi regime. He was accused of sympathy with the Nazis for this and other reasons, and offered the defense that his actions had been governed by a desire to safeguard what was left of German psychiatry after the suppression of Freudian psychoanalysis and the forced exile of many German psychotherapists. Dr. Jung was the developer of the word-association tests which form the basis of present-day lie-detection tests. Two of his concepts which long ago became matters of everyday conversation were those of introversion and extraversion. He viewed the collective and racial unconscious as playing a much larger part in individual human behavior than does the Freudian school.

A public memorial meeting for Dr. Jung will be held at the New York Academy of Medicine on the evening of December 1. Paul J. Tillich of the Harvard Divinity School will be among the speakers. The New York Association for Analytical Psychology and the Analytical Psychology Club of New York are co-sponsoring the memorial.

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### A.P.A. INSTITUTE TO DISCUSS JOINT COMMISSION REPORT

An American Psychiatric Association Hospital Institute to be held in Omaha October 15 to 19 will discuss the report to Congress of the Joint Commission on Mental Illness and Mental Health. The report, published under the title of *Action for Mental Health*, is reviewed briefly in the book

review section of this issue of *THE PSYCHIATRIC QUARTERLY*; and sharp issue with some of its conclusions is taken in a discussion at length in the editorial in this issue, "No Originality of Proposition or Proof," pages 576-585.

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#### LEO KANNER, M.D., TO GIVE FINAL HUTCHINGS LECTURE

Leo Kanner, M.D., widely known as a practitioner, teacher and editor in the field of child psychiatry, will give the thirteenth and last of the series of Richard H. Hutchings Memorial Lectures at the auditorium of the State University of New York, Upstate Medical Center at Syracuse at 8 p.m. on Monday, October 2, 1961. His subject will be "The Development of Child Psychiatry in the United States."

The lecture will conclude a series inaugurated in 1949 in honor of Richard H. Hutchings, M.D., who died in 1947. Dr. Hutchings was professor emeritus of clinical psychiatry at the College of Medicine, Syracuse University; was editor of this *QUARTERLY*; had been superintendent of both St. Lawrence and Utica (N.Y.) state hospitals and had been president of the American Psychiatric Association. The lecture series in his memory was inaugurated by contributions from colleagues and professional associates. The series, originally planned for 10 lectures, was extended by three. The remaining funds in the Dr. Richard H. Hutchings Memorial Trust Fund will be turned over to the Hutchings Psychiatric Undergraduate Society, founded at Syracuse in Dr. Hutchings' honor.

Dr. Kanner, the final Hutchings lecturer, is professor emeritus of child psychiatry at the Johns Hopkins University, Baltimore. He is honorary consultant in child psychiatry at the Johns Hopkins Hospital, is distinguished visiting professor in psychiatry at the University of Minnesota and is visiting professor at the Stanford University School of Medicine. He is a member of the advisory boards of the Woods Schools, Langhorne, Pa., the Devereux Schools, Devon, Pa., the Cove School, Racine, Wis., and the American Child Guidance Foundation. One of the sections of the Devereux Schools is named for him, the Leo Kanner Division. Dr. Kanner is author of half a dozen books on child psychiatry, mental defect and mental hygiene, and more than 250 articles and other contributions on these and other subjects. He is the first recipient (1960) of the annual award of the National Organization for Mentally Ill Children, and he received the award for outstanding contributions in the field of medicine from the Association for the Help of Retarded Children in 1954. He delivered the Maudsley Lecture of the Royal Medico-Psychological Association in London in 1958. Dr. Kanner was born in Austria, is a graduate in medicine of the University of Berlin in 1921, and came to this country in 1924 where he began to specialize in psychiatry.

A distinguished roster of authorities in the field of psychiatry makes up the list of the previous Hutchings Memorial lecturers. The lecturers and

their subjects follow: Winfred Overholser, M.D., "Modern Trends in Psychiatric Treatment," 1949; Harry C. Solomon, M.D., "Treatment of the Psychoses," 1950; Robert A. Cleghorn, M.D., "The Interaction of Physiological and Psychological Processes in Adaptation," 1951; M. Ralph Kaufman, M.D., "The Psychiatrist in a General Hospital Setting," 1952; Bernard C. Glueck, Jr., "Psychodynamic Patterns in the Sex Offender," 1953; Benjamin H. Balser, M.D., "Psychiatric Treatment of Adolescents," 1954; Theodore Rasmussen, M.D., "Surgical Therapy of Focal Cerebral Seizures and Some Contributions to Cerebral Localization," 1955; Lawrence C. Kolb, M.D., "Psychotherapeutic Evolution and its Implications," 1956; Bernard Holland, M.D., "The Social Structure on a Psychiatric Ward, the Interrelationship Between Therapeutic and Antitherapeutic Factors in the Social Structure," 1957; Robert G. Heath, M.D., "Research Studies in Schizophrenia," 1958; George E. Gardner, M.D., "Childhood Development and Childhood Behavioral Disabilities," 1959; and Alvin I. Goldfarb, M.D., "Psychodynamic Concepts in the Psychiatric Care of the Chronically Ill and Aged," 1960.

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#### ARNOLD L. GESELL, M.D., AUTHORITY ON CHILDREN, DIES

Dr. Arnold L. Gesell, recognized for many years as an authority on child development and behavior, died in New Haven, Conn., on May 29, 1961 at the age of 80. Dr. Gesell, born in Wisconsin, attended normal school in that state and later attended Clark University, where he received a Ph.D. in 1906. He taught for several years, became an assistant professor of education at Yale and then obtained his medical degree from Yale in 1915. He served as professor of child hygiene at the Yale School of Medicine and was a founder of the Gesell Institute of Child Development in 1950. He was research consultant for that institute until 1958. He was the author or co-author of numerous books relating to the mental development of children, many of them intended for parents and other general readers.

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#### N.A.M.H. LISTS DECADE'S ACHIEVEMENTS

The National Association for Mental Health lists, in its 1960 annual report, a substantial increase in recoveries from mental illness and a great change in public attitudes toward mental illness as the most important gains in the field in the 10 years since the association was organized to succeed the National Committee for Mental Hygiene. The educational work of the association, the report indicates, had much to do with the changed public attitude. Mrs. A. Felix duPont, Jr., making the 1960 annual report, notes that the organization now has 46 state affiliates, nearly 1,000 local affiliates and more than a million enrolled members and volunteers.

### NEW YORK STATE FILLS THREE MENTAL HYGIENE POSTS

Samuel Feinstein, M.D., assistant director at Gowanda (N.Y.) State Hospital in charge of its J. N. Adam State School Division for the care, treatment and training of mentally retarded patients, has been named director of the new West Seneca State School, it is announced by Commissioner Paul H. Hoch, M.D., of the New York State Department of Mental Hygiene. A photograph and biographical note on Dr. Feinstein will be published in Part 2 of the 1961 PSYCHIATRIC QUARTERLY SUPPLEMENT.

Mrs. Annette C. Saunders has been named to head the New York State department's social services, as acting director; and John W. Schmidt has been named acting director in charge of the office of planning and procedures. Mrs. Saunders, trained originally as a teacher, served at Rome State School and at Letchworth Village, later obtaining her master's degree in social work from the New York School of Social Work and returning to state service as a supervising social worker at Letchworth. She was appointed assistant director of mental hygiene social work on June 18, 1959. Mr. Schmidt, a graduate of an engineering college, has been in New York State service since 1936 and has been with the Department of Mental Hygiene since 1958. He was serving as acting principal examiner when he was named acting director of the planning and procedures office.

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### FREE PAMPHLET ON EPILEPSY IS OFFERED

A free pamphlet on epilepsy, a reprint of an eight-page article originally appearing in *Rehabilitation Literature*, is being offered for distribution by the National Epilepsy League, 208 North Wells Street, Chicago 6, Ill. Called "A Report on the Epilepsy Problem," it is written by George N. Wright, Ph.D., program director of the league. It covers briefly the present position of persons with epilepsy, and their medical, social and legal problems. It is suitable for reading by intelligent patients; and there is a list of 41 references to the medical, general and legal literature which the nonspecialist physician should find useful.

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### NEW CHILDREN'S TREATMENT FACILITIES ANNOUNCED

A new facility in Syracuse, N. Y. for treatment of emotionally disturbed children, and rental of space in a New York City hospital for care and treatment of 200 mentally retarded children are among new projects undertaken by the New York State Department of Mental Hygiene. The Syracuse residential center for emotionally disturbed children will take over and enlarge the Fairmount Division of Syracuse State School. The conversion, with the construction of two new cottages, will provide a capacity of 175 children. The mentally retarded children now in the school will be transferred to other institutions, the capacity of which is now being increased by new school construction.

The new New York City unit to accommodate 200 mentally retarded children, will be provided by the rental of five floors of Gouverneur Hospital, a municipal institution in which in-patient services have been discontinued by the city. It is to be filled by transfers of non-ambulatory patients from Willowbrook State School on Staten Island and will be a division of that school, permitting the institution to accept more young children now on its waiting list. The state has leased the hospital facilities for three years, pending the completion of new state school facilities to serve the New York City area.

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#### LEIGHTON M. ARROWSMITH DIES, AGED 73

Leighton M. Arrowsmith, former administrative adviser to the New York State commissioner of mental hygiene, a man whose career stretched from Harvard and Cambridge Universities through diamond mining to hospital administration, died at his son's home in Lancaster, Pa., after a long illness, on May 11, 1961. Mr. Arrowsmith had retired from the department after almost 25 years of service in 1958.

Mr. Arrowsmith is credited with having developed the hospital equipment standards and specifications now in use in the New York State institutions; he also played an important part in the Department of Mental Hygiene's postwar reconstruction program. Graduated from Harvard in 1909, he studied mining engineering at Trinity College, Cambridge, England, and went to South Africa. He worked for a number of years in gold and diamond mines in South Africa and southern Rhodesia; he later was engaged in mining in Ontario.

Mr. Arrowsmith was administrator of St. John's Hospital in Brooklyn and active in the Greater New York Hospital Association (of which he was a former president when he was named head of a hospital unit of the Office of Price Administration in 1943). At that same period, he became a staff member of the Moreland Act Commission which was inquiring into the hospital operations of the New York State Department of Mental Hygiene. He then joined the department himself, and was administrative adviser for equipment services at the time of his retirement a quarter of a century later.

Mr. Arrowsmith was active as a layman in the Protestant Episcopal Church, and for 15 years was lay head of St. John's Episcopal Church, Brooklyn. He leaves his wife, a son, at whose home he died, and a daughter.

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#### PSYCHOTHERAPY INSURANCE PROJECT FOLLOWED UP

A six-months follow-up study to determine the practicability of insurance for psychotherapy, in which a two-year test project has just been completed, is announced by Group Health Insurance, Inc., of New York City. The

two-year project involved the insuring for psychotherapy of 76,000 group health insurance subscribers and dependents; and the follow-up inquiry will study the claims during this period, the participating psychiatrists' reports on their experiences, and other factors bearing on the question of whether the "average" group therapy subscriber is properly insurable for psychiatric care. Pending the analysis, Group Health Insurance announces that "experience to date" indicates that short-term ambulatory and hospital psychiatric treatment "may well be insurable." In the two-year test project, there were some 850 instances of psychiatric care out of the total of 76,000 group insurance subscribers and dependents.

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#### VINELAND SCHOOL WANTS ELLIS ISLAND

The Training School at Vineland, N. J., is one of a number of organizations seeking to obtain Ellis Island in New York harbor from the federal government. The school proposes, if it can obtain the island, to establish it as a unit of the Vineland institution and employ it as an international diagnostic center and a research and training facility for diagnostic work. Ellis Island was formerly used as a temporary reception center for immigrants. The government vacated it in 1954 but has maintained its buildings.

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#### ALBERT DEUTSCH DIES IN ENGLAND AT 55

Albert Deutsch, widely known as a writer and historian on the subject of the care and treatment of the mentally ill, died suddenly in Horsham, England, June 18, 1961, while he was abroad to attend a meeting of the World Federation for Mental Health. Mr. Deutsch, as a newspaper reporter and columnist, began writing on health and welfare matters for the former New York newspaper, *P. M.* He had worked in the New York State department of social welfare before going into newspaper work and so had a background in his subject. His columns were credited with correction of inadequacies in Veterans Administration facilities after the author had been cited for contempt of Congress for refusal to divulge his sources.

Mr. Deutsch's book, *The Shame of the States*, published in 1948, aroused some professional criticism for what was charged to be lack of discrimination in his attacks on American mental institutions. It was credited, however, with having brought about reforms in several states. Mr. Deutsch wrote *The Mentally Ill in America; A History of Their Care and Treatment from Colonial Times*, a standard work on its subject. Another of his books which had wide circulation was *Our Rejected Children*. Mr. Deutsch received a number of awards for journalism and the Adolf Meyer Memorial Award in mental health. He was made an honorary fellow of the American Psychiatric Association.

## ART THERAPY BULLETIN ISSUED

The *Bulletin of Art Therapy*, a new quarterly and the first periodical in its field, is scheduled to distribute its first issue in September 1961. It will cover "art in education, rehabilitation and psychotherapy." A copy of the first issue may be obtained by writing to the editor, Miss Elinor Ulman, 634 A Street, S.E., Washington 3, D.C. The subscription price for the following four issues will be \$3.00.

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## NEW BLONDIE BOOK NOW AVAILABLE

A new edition of the New York State Department of Mental Hygiene's mental health comic book, *Blondie*, is now available for distribution. The *Blondie* booklet has made something of a best-seller record in its field since the first edition of it was produced in 1950. The booklet features Chic Young's *Blondie* and her family in lively incidents aimed to promote mental health. Margaret M. Farrar, director of education and information for the Department of Mental Hygiene, and Joe Musial, art director of *King Features*, collaborated in adapting the Young characters for mental hygiene purposes. Single copies may be obtained free by writing to the Office of Mental Health Education and Information, 240 State Street, Albany. Limited numbers of free quantities are available to recognized agencies and organizations in New York State.

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## EXCERPTA CRIMINOLOGICA IS ANNOUNCED

*Excerpta Criminologica*, a new abstracting journal, is announced as a bi-monthly publication containing abstracts of the world's literature in criminology. Its first issue was for January-February 1961. Information may be obtained from the Excerpta Medica Foundation, New York Academy of Medicine Building, 2 E. 103 Street, New York 29, N. Y.

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## SIMON ROTHENBERG, M.D., PSYCHOANALYST, DIES AT 78

Dr. Simon Rothenberg, pupil of Freud and believed to be the oldest practising psychoanalyst in this country, died while on vacation in Pittsfield, Mass., on August 10, 1961 at the age of 78. Dr. Rothenberg, born in Estonia, was brought to this country as a child. He attended the New York City public schools and Columbia University and received his degree in medicine at the Long Island College of Medicine in 1911. He began private practice after studying in Europe with Sigmund Freud and at the time of his death was assistant clinical professor of psychiatry at the State University of New York, Downstate Medical Center and was consultant psychiatrist to three Brooklyn hospitals. He was a charter member of the New York Psychoanalytic Society and the American Psychoanalytic Association.

### COMMUNITY PROGRAM AIDS 120,000

The community mental health services of New York State aided approximately 120,000 persons during 1960, it has been announced by Hyman M. Forstenzer, director of community mental health services for the New York State Department of Mental Hygiene. A total of \$26,151,768 was spent for these services during the year; of this, \$11,470,383 was state aid. Mr. Forstenzer reported that services in the program included 159 out-patient psychiatric clinics, 80 in New York City and 79 in the rest of the state.

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### PENNSYLVANIA COMMISSIONER KILLED IN AUTO CRASH

Robert A. Matthews, M.D., commissioner of mental health and deputy secretary of welfare for the Commonwealth of Pennsylvania, was killed in an automobile accident in New Jersey on June 23, 1961. He was 58 years old.

Dr. Matthews had headed the Pennsylvania mental hospital system since 1956. He was professor and head of the department of psychiatry at Jefferson Medical College of Philadelphia. A graduate of that medical college in 1928, he had first joined the faculty there in 1930. He was professor of psychiatry and head of the department of psychiatry at Louisiana State University School of Medicine in New Orleans before his appointment as Pennsylvania commissioner of mental health. He returned to the Jefferson faculty, and was named head of the psychiatry department in 1958. Dr. Matthews was active in professional association work and was president of the Pennsylvania Psychiatric Society in 1960.

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### UNDERGRADUATE PSYCHIATRIC NURSING GRANT RENEWED

A renewed \$15,000 National Institute of Mental Health grant for the undergraduate training in psychiatric nursing of school of nursing students has been announced by Boston University. The grant will cover some of the costs of teaching psychiatric nursing and mental health concepts to undergraduates in the university's school of nursing. It becomes effective in September and will extend for a year. The National Institute of Mental Health made its original grant in 1956; and \$73,000 has been made available for its purposes in the five-year period since. Field work experience in the care of psychiatric patients at home is a feature of the training offered.

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### DR. HEINRICH RACKER, ANALYST, DIES IN BUENOS AIRES

*Revista de Psicoanalisis* has asked the *QUARTERLY* to make note of the death of Dr. Heinrich Racker, whom that journal regarded as one of

its most distinguished collaborators, in Buenos Aires on January 28, 1961. Dr. Racker was a member and training analyst of the Argentine Psychoanalytic Association and had recently become director of the Institute of Psychoanalysis.

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#### PRACTICAL NURSE SCHOOL TO OPEN

Plans to establish a school of practical nursing in an effort to increase the nursing services of the state schools for the mentally retarded have been announced by Commissioner Paul H. Hoch, M.D., of the New York State Department of Mental Hygiene. The school is to be opened in September at Willowbrook State School, Staten Island, and the first class is expected to have about 35 members. It will offer a 12-month course, leading to eligibility for the New York State licensing examination for practical nurses. Mary Kelly, formerly in charge of student nurse education in mental retardation at Willowbrook, is principal of the school. Priority in enrollment is given to department employees who have been associated for more than a year with one of the state schools.

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#### MEETINGS AND COURSES ARE ANNOUNCED

The Graduate School of Medicine of the University of Pennsylvania announces a course in medical hypnosis to be given for two semesters in 1961-1962 at the Institute of the Pennsylvania Hospital in Philadelphia. The course, expanded from 72 hours to 96, will be in 24 weekly afternoon sessions, beginning October 4. Lauren H. Smith, M.D., professor and chairman of psychiatry of the department of neurology and psychiatry at the Graduate School of Medicine, heads the teaching staff of eight.

An interdisciplinary symposium on "expanding goals of genetics in psychiatry" will be conducted in the eighth floor auditorium of the New York State Psychiatric Institute on Friday and Saturday, October 27 and 28, in conjunction with the sixth annual meeting of the Eastern Psychiatric Research Association. The symposium will be under the joint auspices of the New York State Department of Mental Hygiene and the College of Physicians and Surgeons of Columbia University.

The Society for the Scientific Study of Sex announces that its fourth annual meeting will take place on November 4 in the Barbizon-Plaza Hotel, New York City. Symposia will be conducted in the morning and afternoon on the topics of "sex and aging," and "sex factors in schizophrenia."

The Academy of Psychoanalysis announces that the theme of its two-day mid-winter meeting at the Hotel Commodore, New York City on December 9 and 10 will be psychoanalytic education. Chairmen for the four sessions are announced as Roy R. Grinker, Sr., M.D.; Sandor Rado, M.D.; Jules H. Masserman, M.D., and Lilly Ottenheimer, M.D.

The American Academy of Psychotherapists announces the theme of its sixth annual conference will be "Failure in Psychotherapy—Process and Person." The meeting will be on Saturday and Sunday, October 14 and 15 at the Hotel New Yorker, New York City.

A free course for psychiatric interns and residents of hospitals approved by the American Medical Association, "Orientation Course in the Theory and Practice of Psychoanalysis," will be given by the American Institute for Psychoanalysis at the institute in New York City commencing October 3, 1961. There will be a series of five Tuesday afternoon lectures commencing on that date. A second series will be given starting March 6, 1962.

The State University of New York, Downstate Medical Center has asked this journal to call attention to its two-year program of research training in psychiatry leading to the degree of doctor of medical science. The program is open to physicians who have completed three years of residency training in psychiatry. Residents who have completed two years will be accepted for a three-year course. Fellowship grants will be given to accepted candidates. Applications for the academic year beginning in September 1962 should be submitted before February 1, 1962.

The Second International Conference of Human Genetics will open in Rome, September 7 and last through September 12, 1961. An official post-conference tour to Naples, Paestum, Salerno and Capri is being offered to conference members.

The twelfth annual Lindauer Psychotherapy Week will be conducted, as in previous years, at Lindau on Lake Constance, Germany, from April 30, 1962 through May 5. The main subject will be the physical symptom as a psychotherapeutic problem. There will be other lectures on psychotherapy in clinical institutions. The conference will include a workshop, with colloquia on autogenic training, hypnosis and related subjects. Inquiries should be addressed to: Sekretariat, Lindauer Psychotherapiewoche, Munich 2, Dienerstrasse 17, Germany, no later than January 1962.

Trans-International Psychosomatic Seminar announces that a third around-the-world trip will take place during the winter of 1962 and 1963 on the *S. S. President Adams*. This is a non-profit educational endeavor in which clinicians who volunteer to take part in giving free lectures in different parts of the world will pay their own tour expenses. The announced itinerary covers the Far East, Egypt, Italy, Spain and France. J. L. McCartney, M.D. of Garden City, N. Y., is medical director.

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#### PROFESSIONAL SOCIETY OFFICERS ARE ANNOUNCED

Officers for 1961-62 have been announced by a number of professional organizations. Jack L. Rubins, M.D., is president for that year of the

Association for the Advancement of Psychoanalysis. Theodora Abel, Ph.D., has been named president, and Ida Mermelstein, M.S.W., president-elect, of the Professional Association of the Postgraduate Center for Psychotherapy. Albert Ellis, Ph.D., has been elected as the first president of the Society for the Scientific Study of Sex. Roy R. Grinker, M.D., of Chicago has been elected president and Sandor Rado, M.D., of New York, president-elect, of the Academy of Psychoanalysis.

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April, 1944.....	Vol. 18, No. 2	October, 1957.....	Vol. 31, No. 4
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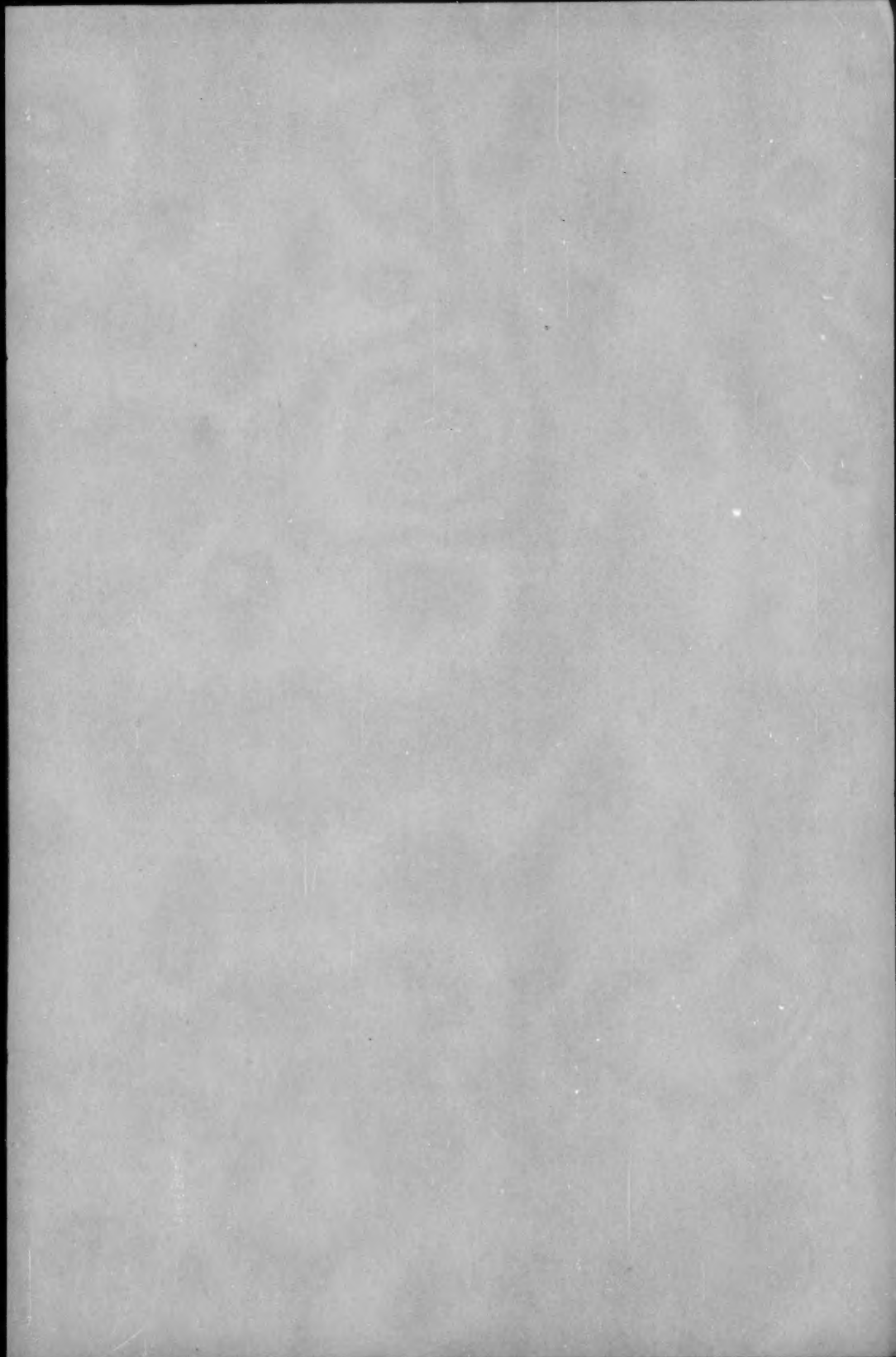
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# THE PSYCHIATRIC QUARTERLY

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## TABLE OF CONTENTS

	PAGE
Some Aspects of Self-Mutilation in the General Population of a Large Psychiatric Hospital. R. H. Phillips and M. Alkan	421
Recurrent Self-Mutilation. R. H. Phillips and M. Alkan	424
Effects of Premedication with Meprobamate and Phenobarbital on Adrenocortical Response to ECT. F. CoTui, W. Brinitzer, and A. Orr	432
A Model for a Sociotherapeutic Approach in the Treatment of Psychotics. T. Ishiyama and W. L. Grover	445
Transformation of Oral Impulses in Eating Disorders: A Conceptual Approach. H. Bruch	458
The Use of Glucagon in Insulin Coma Therapy. B. Blackman	482
The Application of Psychodynamic Thinking to Hypnotic Behavior. L. J. Bookbinder	488
Dynamics in Hospital Recovery of Psychotics. C. Watkins	497
Events and Conscious Ideation Leading to Suicidal Behavior in Adolescence. H. I. Schneer, P. Kay, and M. Brozovsky	507
Some Observations on the Emotional Position of the Group Psychotherapist. W. D. Ross and A. Brissenden	516
Causes and Types of Narcotic Addiction: A Psychosocial View. D. P. Ausubel	523
II. Primary Gain: The Game of Illness and the Communicative Compact in the Borderline Patient. J. M. Scher	532
Suicide Attempts of Puerto Rican Immigrants. E. C. Trautman	544
Gasoline Addiction in Children. J. J. Lawton, Jr., and C. P. Malmquist	555
A Preliminary Study of Hostility: The Hostility Ratio. R. H. Archer	562
Love. J. R. Cowen	575

### *Special Departments*

Editorial Comment:	
"No Originality of Proposition or Proof"	576
Letter to the Editor	586
Book Reviews	587
News Notes	620

